1			1 - For State Registrar			artment of Health and I	Re	g. No. 2007	12501
	Physici /Medi		1. Decedent's Name (First, Middle, Charles	Last) H		Simms	2. Date of Death	28 2007	3. Time of Death A M
	Examir			ledical C	er) NTER Age (In yrs. last birthday)	4b. City, Town, pr Location of Death BALTMURE If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death	place (State or Foreign
	Director		216-12-3575 Usual Residence of Decedent 10a. State 10b. County	1 X JM 2□ F	87 Yrs.	Months Days Hours Min.	Jan 6	Year) Cou 1920 Mar	yland
	a-f shov	ctor	Maryland Anne	Arunde1	Annapol				10d. Inside City Limits 1 Y Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cou	intry?
	s 23a	rai	29 W. Washing			21401		USA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Evaninar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorced	16 VA - Chin	□No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4)	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	6b. Kind of Business/li	ndustry
21	filed wi Hygien other th	Con	7th	0	Ma	intenance		Legum Rel	ator
Maryland	should be filed withir nd Mental Hygiene. marked other than imatic event, ILE M.	To Be	17. Father's Name (First, Middle, L Charles Simms			Rose M	ne (First, Middle, M	iaiden Sumame)	
aryl	2 should and Men is marke	ř	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street and Number or Ru		City or Town, State, Zi	p Code)
	1 and 2 Health a om 27 is		Florence Hawk	ins(Daug		North Kenwood	Ave Bal	timore, M	d. 21205
nore	ages 1 ant of He it: If iter y or oth		20a. Method of Disposition 1			esition (Name of matory or other place) d Veteran 4-3		oc. Location - City or Trownsvill	
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service L		TAY	miamo Referencia Son 21 West St. An	s Mortu	ary, P.A.	
ш			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause on each	sed the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	_aC	ardiac :	Infortion			Onset and Death
В	/Medical Examiner			Due to (or	as a consequence of):		jeisk		
		ner	Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of	or reg of 1	ecyc		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (es	/				
8760,	cate be ex ohysician the burial	ledicai E		d.	as a consequence of):				
9	entifica ding ph	/Med	IF FEMALE:	220 14 1120 21400					
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	very Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	s contributing to deat	h but not resulting in the u	nderlying cause given in Part I.		acco use contribute to	the cause of death?
of Vital Records,		Completed					24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of
Ζ		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 / np	atient 2 ER/Outpatier	Other	ath (Check only one		Z.)
	iding Physin. After this funeral di	n: To	27. Manner of Death	28a. Date of I			28d. Describe ho	nce 6 Other (Spec winjury occurred	(Y)
sior	tendir eath. tor: Af the fur	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	ition	and the second s	M 1 ☐ Yes 2 ☐ No			
Division	al or At s after d il Direct id in by	Certification:	4 Homicide determin	ed 286. Place of	Injury - At home, farm, str etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai (29a. Certifier Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	s of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	12	2	29c. License number		d. Date signed (Month	
	02/		2 11	12		AU4176435	517536	March o	28, 200/
	27			H BECKER	mD	Print) NORTH GREE	Ne Steer	+ Bactimus.	md 2120/
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 0 3		strar's Signature	ed .			

State of Maryland / Department of Health and Mental Hygiene)

	_							
2	0	0	7		2	5		1
).	-40	-		9	bud.	-	_	

				,	Certificate of	Death	Re		12302
			1. Decedent's Name (First, Middle, Las	it)			2. Date of Death Month	n Day Year	3. Time of Death
	Physicia * /Medic		Edith Mar	rie Sutton			March 2		7:50 A.M.
1	Examin		4a Facility Name (If not institution, give	street and number)	4	4b. City, Town, or Lo	cation of Death	4c. County of Dea	ath
		a	The Annay	oolitan		Annapoli		Anne aru	
	Funeral Director		5. Social Security Number 6. S 214-24-9228 1	7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 15	,1913 No	irthplace <i>(State or Foreign</i> Co <i>untry)</i> ew York
	D >		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Location				10d. Inside City Limits
	shov	<u> </u>							1 Ves 2 No
	he M	Director	Maryland Anne art	ındel	Annapolis 10f. Zip Code		10	og. Citizen of What C	Country?
	Mith t	<u>ا</u> ق							•
	s 23	Funeral	18 Jefferson Plac	CE 12. Was Decedent Ever in U,S.	21401			United Sta	
	er de	٤	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
Baltimore, Maryland 21215-0020	P	امِ ا	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2√√No	Specify:		Specify:	White
5	72 h	etec	15. Decedent's Ed (Specify only highest gra		6a. Decedent's Usual Occup (Give kind of work done)	during most of worki		16b. Kind of Busines	s/industry
7	ithin ser.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1		D	
2	led w lygiel lygiel lygiel nt, th		12 17. Father's Name (First, Middle, Last)		Buyer	18. Mother's Name	/First Middle N	Retail	
anc	d a b	Be	Charles Fair	.m.o.m					
ž	d Mer marke	ှ	19a. Informant's Name/Relationship		19b. Mailing Address (Street		lie Nieb		Zin Code)
Z	2 2 2 2								
e,	Health Health Hem 27 i		Wayne A. Lee / N 20a. Method of Disposition	lewphew]	10 Pleasant S	Springs Dr	rive,Cen	treville, 20c. Location - City o	MD 2161/ or Town, State
٥	ages or or o	ļ	1 X Burial 2 ☐ Cremation 3 ☐	Pomoval from State com	etery, crematory or other place. Anne's Cemete	ce)			, Maryland
i =	it. Partura		4 Donation 5 Other (Specify						ral Home, In
Ba	permit. Pages 1 a Department of Hes Important: if Item any injury or othe		21 Signature of Funeral Service Licen	Kutta				•	s, MD 21401
			23a. Part 1 Enter the disease, or comp	plications that caused the death.	Do not enter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
18	Physician		shock or heart failure. List only					1	Onset and Death
)	/Medical		Immediate Cause (Final disease or condition	CONG	ESTIVE	E (4151	IRT.	TYAIL UA	LE
	Examiner		resulting in death)						
	P	ine		HRTEI	s a consequence of): RIOSCLE	ROTIC	HEI	4RT	
	ertificate be executed ing physician end e as the bunal-transit	Examiner	Sequentially list conditions, if any leading to immediate		s a consequence of):		S	ICEA	SE
60,	be ey ician buna	e E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
68760,	phys the	Medicai	resulting in death) Last	Due to (or as	s a consequence of):				
×	ding ding			d					
Bo	attend I for us	Physician/				on in Donal	Ook Didto	hanna una nontribu	ite to the cause of death
P.O.	that the di ed by the detached	ysi	Part II. Other significant conditions of		ng in the underlying cause giv	en in Part I.			Probably 4 Unknow
	es that igned b be deta	by P	DEMEN	0111			101	20.110	
of Vital Records,	v requires that the death certificate be executed been signed by the attending physician end should be detached for use as the burial-transit	ted b					24a. Was ar		Were autopsy findings available prior to completion of cause
ec	2 s b	Completed						2.2	of death?
<u> </u>	The law ate hes b page 2 s	5					111Y6	3 2 XNO	1 ☐ Yes 2 ☐ No
ita	lcian: The l certificate he rector, page	Be	25. Was case referred to medical examiner?		l au	26. Place of Death	Check only on	6)	
\neq	S S S	٥	1 ☐ Yes 2 No		VOutpatient 3□ DOA Oth	4 Drursing Ho		nce 6 □Other (Sp	pecify)
Ē	ding Ph h. After th funeral	Ë	27. Manner of Death 1 □ Natural 5 □ Pending	(Month, Day Year)	Bb. Time of 28c. Injury Wor	rk?	28d. Describe ho	w injury occurred	
Si Si	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2 □ No	Ont Lagation /St	root and Number or	Rural Route Number,
Division	or Attendent efter deatl	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, tarm, street, tactory, onice		City or Town	n, State)	ribrar ribbie ribribor,
	To the Hospital or Attent within 24 hours efter deati To the Funeral Director: completely filled in by the	<u>ဗ</u>	29a, Certifier 18 Certifying Ph	ysician: To the best of my knowle	doe, death occurred at the tin	ne, date and place.	and due to the ca	ause(s) and manner	as stated.
	To the Hospital within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurr	ed at the time, da	ate and place, and d	ue to the cause(s)
	To th	ž	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
			ATYN	$\sim m c$) 00	0 631	45	3/20	1107
	.1-		30 Name and address of person who	completed cause of death (Item 2	3a) (Type, Print)		2. 0	1 - 1)
		4	HRVIND DO	35H1 11		LERF	(D)	LEN	DUKNIEN
	Stat Registra		31. Date filed (Month, Day, Year) APR 0 2	32. fegistrar's Signatur	* porte				

			For State Registrar	State of Maryland	d / Depa		t of H	lealth an		ntal Hygi	-	12503
			Decedent's Name (First, Middle, Last)						2.	Date of Death		3. Time of Death
*	Physici /Medic	al	Doris Smit	h		4h City	Town o	r Location of D		Month March	28 200 4c. County of Deat	
1-	Examin	er	Washington Ad		- 1			Takoma		le .		gomery
*	Funeral	27.5	5. Social Security Number 6. Sex					If Under 24 I		Date of Birth (Month, Day,		hplace (State or Foreign
187	Director	3.	577-34-9477	M 2⊠F 78	Yrs.	Months	Days	Hours N	Min. J	$\frac{\text{(Month, Day,}}{\text{uly 29}}$		ash., DC
	Maryland -f ehow lied et	tor	10a. State 10b. County Maryland Prince G		, Town or Lo		Diet	rict H	o i ch	t c		10d. Inside City Limits 1 XYes 2 No
	with the	Director	10e. Street and Number	eorge s		10f. Zip					g. Citizen of What Co	_
	23.	rai	7502 Val Lane	12. Was Decedent Ever in U.	C 12	Man Dann	dont of H	207		Vac or No	United 14. Race - Ame	States
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow other traumatic event, the Modical Exeminer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		If Yes, spec		ispanic Origin? an, Mexican, Pi Specity:	uerto Ric	an, etc.)	Black, White	
215-0036	n 72 hou nature	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece (Give		rk done	during most of	working	1	6b. Kind of Business/	Industry
_	within ene. then	ш	Elementary/Secondary (0-12)	Colfege (1-4or 5+)				t Spec	1011	e t	Cov	ernment
d 2	filed Hygi ther	ပို	17. Father's Name (First, Middle, Last)	2		COII	LLac				aiden Sumame)	eriment
Maryland	S should be filed and Mental Hygi is marked other surnatic event,	To Be	Alger G. J. Wr	ight					M	aude Ro	binson	
<u>></u>	shoul nd Me mark mati	F	19a. Informant's Name/Relationship (Ty)	0	19b. Maili	ng Address	(Street	and Number o			City or Town, State, 2	Zip Code)
	1 and 2 s Health ar iem 27 is		Melody Smith/Da	ughter	6108	- 42	nd A		102,	Hyatts	sville, MD	20782
ore	0 0		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → P	emoval from State	lace of Dispo emetery, crei	matory or c	other place	. 1	Date		Oc. Location - City or	Town, State
Ë	Pag ment ant: lury c		4 ☐ Donation 5 ☐ Other (Specify)	Li	ncoln	Memor	ial	Cem. 4			Suitland	·
Baltimore,	permit. Page Department: Important: II eny injury o		21. Signature of Fure ral Service License	1010 TO X 111_		4	001		g Rd	., NE	Funeral How Wash., DC	me 20019
	Physician	2 1	23a. Part1. En l'ithe disease, or complishock, or h'art faiture. List only or Immediate Ca.s. (Finat disease or continuo resulting in death)	cations that caused the death	valu	ter the mod	e of dyir	ig, such as car	rdiac or re	Spiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequence of Seps 15	•							day
Ī	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as a consequence of the to (or as a consequence of		du	tee	e co	9 00	julo	palmi	days
68760,	cate be e physicien the buria	cal		Atrial 1	Chn	illa	tu	où.				yrs.
P.O. Box (Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pi □ Other (sp		,			23d. Date of del Month	ivery Day Year
rds, P	w requires that been signed I should be det	þ	Part fl. Other significant conditions con	ntributing to death but not resu	ulting in the u	inderlying o	ause giv	en in Part f.			accoluse contribute to s 2 No 3 Pr	
of Vital Records,	'he law requ e has been age 2 shoult	Completed								24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
tal	icien: Th certificate rector, pag	ø	25. Was case referred to medical					26. Place of	Death (C	1 ☐ Yes 2 Check only one		2010
>	ysici s cer direct	To B	examiner?	lospital:	ER/Outpatier	nt 3 🗆 D0	Oth Oth	05			nce 6 Other (Spe	cify)
ion of	nding Physith. :: After this e funeral di		27. Mann of Death 1 Vilatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. fnjur Wor		280		w injury occurred	
Division	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factor	y, office		281	Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno nar: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred ivestigation	at the tirn, in my o	ne, date and p pinion, death o	olace, and	due to the ca at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	Fo th within Fo th compl	Me	29b. Signature and title of certifier			290	c. Licens	e number		29	d. Date signed (Mont	h, Day, Year)
			xxau	12 · 11	0.		D5	0987	7	La constitue de la constitue d	3-30-	07.
2	(2)		30. Name and address of person who co	impleted cause of death (fter	-		(91	2519	erel	blus	m02	0883
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		- 17	70	7. 11	<u> </u>	00-00)	
43	Registi	ar	APR 0 4 2007	June D. P.	The same							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Janet Targett Satterfield 2007 Mar. 30 1:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Months Days 1 M 2 TF 75 Feb. 28, 1932 Washington, 579-46-4749 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits TXTYes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2629 Nicholson Street, #3 20782 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4 Secretary Larson Engineers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Targett Alice Adeline ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph F. Satterfield - Husband 2629 Nicholson St., #3, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/4/2007 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hancratu Concer disease or condition resulting in death) Due to (or as a consequence of): OBSTRUCTUL PULMORM DIKONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine hypo Volenic Shock resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Anpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Examiner requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician:

Funeral

Director

r 28a-f show notified at show

"natural", or items 23a or

the Medical

7 is marked other than traumatic event, the Me

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important; if item 27 is marked othe any Injury or other traumatic event, once.

Physician

/Medical

physician and strans

use as

for

the

signed by tl d be detach

peen

certificate

this After thi

death.

has e 2

page

Hygiene.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Funeral Director completely filled in by the within 24 hours after o Hospital To the P

31. Date filed (Month, Day, Year) State APR 0 4 2007 Registrar

(Check only one)

29b. Signature and title of certifier

truTu



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Hamulton

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month 03 **Physician** SNIDIT 4:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Sunvalley Home Care Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 May 19, 1914 Director 92 Virginia 226-46-9360 Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Glen Burnie Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a U.S. 21061 must 7711 Ouarterfield Road Suite B-6 permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No White If Yes, Give Year or Dates: Specify: þ 3₺Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roxie Hoover Charlie Hedge 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Quarterfield Rd., Ste. B-6, Glen Burnie 21061 Dr. Earl Hamilton/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4/2/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service /icensee 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 3401 Bladensburg Rd., Brentwood, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-tran and Due to (or as a consequence of) as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Dav 5 ☐ Other (specify) detached 9□Unknown 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page ; performe this certificate or Attending Physician: DOMICILAMY 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of partifie

Registrar

DHMH 17 Rev 1/2001

State

ENSE 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 03 2007

MA M445

32. Registrar's Signature

Physician /Medical **Examiner**

filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at Medical the

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

certificate be executed sician and burial-tran the as attending p been signed by the should be detached or Attending Physician: this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

.O. Box 68760.

<u>م</u>

Division or Vital Records,

To the Hospital

Smith, Karen

1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 6:55P Karen Ann Smith April 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital Baltimore None If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 □ M 2 🛣 F 214 66 4721 53 Aug 31, 1953 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d, Inside City Limits 10a. State 1 Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21043 4907 Montgomery Road United States Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Child Care Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linuy or other traumatic event once. Be Albert M. Smith Frances Joan Whiteford ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Montgomery Road Ellicott City, MD 21043 Albert M. Smith/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State Crest Lawn Mem. Gard. 4-7-2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee M01044 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hours Immediate Cause (Final Septic Shock disease or condition resulting in death) Due to (or as a consequence of) 2-3 Days Peritonitis Sequentially list conditions, if any, leading to immediate cause of the distribution of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 4 Days Perforated Stomach Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Morbid Obesity 1 ☐ Yes 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 2 🗆 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) **S**IZ*No 1 Inpatient 2 ER/Outpatient 3 DOA ို 1 TYes 28b. Time of 27. Manner of Death 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 05



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

D0037359

April 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0420 March 29 2007 MARY ELLEN SPIES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Talbot Hospita Memoria If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, MAY 22, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Days Year) 1924 **Funeral** 1 M X F DELAWARE 82 Director 220-12-0411 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State r 28a-f show notified at 1 Yes 2 □ No CAMBRIDGE Director DORCHESTER MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number marked other than "natural", or items 23a or marke event, the Medical Examiner must be re-USA 21613 407 PLEASANE ST. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyggene. Important: If Item 27 is marked other than "natural", or items 2 once. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify. Ş Q WHITE 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 0 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAY BELLE LEAGER BENJAMIN F. MCCLAIN P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 NORTH SPRINGVIEW DRIVE, DOVER, DE 19901 DOROTHY SCHAUBER/SISTER-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation EASTON, MARYLAND 4/3/2007 SPRING HILL CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST. EASTON, MD 21601
Approximate 21. Signature of Funeral Service Licensee MERCE RO JOHD Z. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** one disease or condition resulting in death) 27-07 /Medical Due to (or as a consequence of) Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed burial-tran and Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **A** 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No has page 2 certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death e Funeral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2

Registrar DHMH 17 Rev 1/2001

State

5

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DETRICH M.D.,

2007

Mary

29c. License number

140 S. WASHINGTON ST., EASTON, MD 21601

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland		artment tificate			ind Me		giene Reg. No.	17	12508
	Physici		1. Decedent's Name (First, Middle, Grace F. Selle								2. Date of Dea Month March	Day	Year 107	3. Time of Death $10:00 \text{ AM}^{\text{M}}$
	/Medic Examin		4a. Facility Name (If not institution,		ber)		4b. City,	Town, or	Location o	f Death	naren	4c. County of		110.00 111
п	LXIIII	-	Peninsula Regio	nal Medica	al Cent	er		isbu				Wicom		
	Funeral			6. Sex 7	. Age (In yrs. I	ast birthday) Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da			place (State or Foreign ntry)
	Director		213-22-6941 Usuel Residence of Decedent	10 111 2/41	85	115.					01/10/	1922	Mary	yland
	land OW		10a. State 10b. County		10c. City	, Town or La	cation						1	0d. Inside City Limits
	Mary I-f sh	ţ	MD Wicomi	co	Sa1	lisbury	V							1 Yes 2 No
	th the	jred	10e. Street and Number				10f. Zip	Code				10g. Citizen of Wh	nat Cour	ntry?
	23a d	la l	137 Francis Dr						1804			USA	14	- Indian
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Madical Exams are must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	No No		Was Deced f Yes, spec 1 ☐ Yes 2	10	spanic Origin, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or No lican, etc.)	Specify:	, White,	ean Indian, etc. ite
Maryland 21215-0036	hin 72 hor e. an "natura Medical i	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)	4or 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	I Occupa rk done d se retired,	ition <i>Jurin</i> g mosi)	t of workin	g	16b. Kind of Bus	iness/In	dustry
2	ed wit /giene /er th	Son	12	none		Hor	nemake	er	45.44.4	1. 1/2	(P ²) k d'.d dl-	Own Hom		
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, L	ast)								Maiden Sumame	,	
<u> </u>	hould d Mer marks marks	ဥ	Curtis Farrow 19a. Informant's Name/Relationsh	in (Type Print)		19b. Mailir	ng Address	(Street a	Jun		ArroW Route Numbe	ar, City or Town, S	tate, Zir	o Code)
Ma	d 2 sith an Ith	8	Edwin Sellers/			1	_					MD 2180		
ē,	t Heal tam itam	L	20a. Method of Disposition	~		lace of Dispo emetery, crei	sition (Nan	ne of ther place	e)	Da	ate	20c. Location - C	ity or To	own, State
E S	Pages ent of nt: If i		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tate	chwoo				4/05	/2007	Princess	An	ne, MD
Baltimore,	permit. Departir Importa any inju		2). Signature of Fun and Source L	icensee	M00295	H	Name an inman 1673	Fun	eral	Home	Princ	ess Anne	. M	D 21853
ľ			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that ca	used the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			20 ~	11							Onset and Death WEEK
	/Medical Examiner	-	resulting in death)	Due to (o	r as a consequ	uence of):								1.00
	Exammer	_	Sequentially list conditions,	b	or as a consequ	OK!							0	- weer
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (c	as a consequ	derice or _j .								
	al-trai	Xar	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	uence of):								
8760,	ate be executed thysician and the burial-transit	ical		d			_							
9	tificat ig phy as th	led							-					
P.O. Box	that the death certificate be executed led by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown		th 2 Fete int at time of d	I death 3	⊒Ectopic pr ⊒ Other (sp					23d. Date Mont		ery Day Year
	quires that t n signed by uld be deta	þ	Part II. Other significant conditio	ns contributing to dea	ath but not res	ulting in the u	inderlying c	ause give	en in Part I				bute to t 3 ☐ Prot	the cause of death?
l Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	Completed			<u></u>			.			24a. Was auto perfo 1 \(\text{Yes}	psy pr prmed? de	rior to co	opsy findings available ompletion of cause of 2 \(\square\$\) No
/ita	Physician: r this certifica ral director, i	Be (25. Was case referred to medical examiner?					I Out		of Death	(Check only	one)		
J	Physi this c al dire	ဥ	1 Yes 2 No 27. Manney of Death	Hospital: 1 H		ER/Outpatie			4 🗆 N			dence 6 Othe		fy)
uo	ling After une	flon	1 ☑Natural 5 ☐ Pending	(Month	, Day Year)	Injury	M	28c. Injury Wori 1 □ '	k? Yes 2 □					
Division of Vital	tan leat lor: the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At he g, etc. (Specif	ome, farm, st	reet, factory	y, office		2	8f. Location (City or To	Street and Numbe wn, State)	r or Rur	al Route Number,
	Hospita 24 hours Funaral tely filler	edical C	29a. Certifier 1 Certifying (Check only 2 Medicel 8	g Physician: To the Exeminer: On the ba and mann	sis of examina	owledge, deat	th occurred ovestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) and man date and place, a	ner as s	stated. to the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier				290	c. Licens	e number		- Andrews	29d. Date signed		Day, Year)
}			Rolitall	2 M, D	-			D291	168		4	13/200	7	
6			30. Name and address of person was Robert Allen,	who completed cause	of death (Iten			, Sal	lisbu	ry, M				
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0		ogiarar's Signa		Court	رع						

			For State Registrar	e of Maryland		rtificate of L			Reg. No.	2007	12509	- Company
	Physicia		Decedent's Name (First, Middle, Last) John	Edward	Se	edl a k		2. Date of Dea Month April	Day	Year 2007	3. Time of Death	
	/Medic		4a. Facility Name (If not institution, give street as	nd number)		4b. City, Town, or	Location of Death			ounty of Death		_
	Examin	er	Frederick Memorial Ho			Freder	ick		F	rederio	k	
- 20	Funeral		5. Social Security Number 151-32-4893 6. Sex 1 1 2 M 2	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v, Year)	Cou	place (State or Foreign intry) ew Jersey	
1 1	Director		Usual Residence of Decedent		Town or Lo	notion		reb. z	/ , 1.	744 N	10d. Inside City Limits	_
	farylan show ed at	or	10a. State 10b. County	10c. City,	Town or Lo	rederick					1 No 2 No	
	the N 28a-i notifii	Director	Maryland Frederick 10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	untry?	_
	h with 3a or st be		918 Sweet Gum Court			2	1701			U.S.A		_
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	Arn	s Decedent Ever in U.S led Forces? Yes 2 No 196 es, Give	13. 1 1 –	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Amer Black, White Specify:	e, etc.	
2	hours a tural", o	ed by	3 ☐ Widowed 4 ☐ Divorced Yes	ir or Dates: 196	3 16a. Dece	dent's Usual Occup	ation			d of Business/I	White ndustry	
2 2	thin 72 e. an "na' Medic	Completed	(Specify only highest grade comp	leted) lege (1-4or 5+)	(Give life.	kind of work done on DO NOT use retired	furing most of wor	king		_		
7	ed wit ygien ner th	Con		5+		Legal As	sistant 18. Mother's Nar	ne (First Middle	Maiden S	Law Surname)		_
<u> </u>	t be fill ntal H ed ott	Be	17. Father's Name (<i>First, Middle, Last</i>) John E. Sedlak					Mary F.		,		
Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type. Prin	nt)	19b. Maili	ng Address (Street					(ip Code)	
2	nd 2 salth ar 27 is 27 is r trau		Teresa L. Sedlak	(Wife)	918	Sweet Gum	Crt. Fr	ederick,	Mar	yland 2	1701	
, C	es 1 a of Hea item		20a. Method of Disposition 1 □ Burial 2 【X Cremation 3 □ Remova	20b. Pl	ace of Dispo emetery, cre	osition (Name of matory or other place	e) Anr	Date il 10,	20c. Loc	ation - City or	Town, State	
Ĕ	Pag ment ant: If		4 □ Donation 5 □ Other (Specify)	Smi		rg Cremat	ory -	2007			g, Maryland	1
Dallillo	permit. Depart Import any in		21. Signature of Funeral Service Licensee	wis mole		2. Name and Addre 2525 Brad					eral Home and 21783	
			23a. Part1. Enter the disease, or complications	that caused the death						, 5-	Approximate Interval Between	
	Physician	ł į	shock, or heart failure. List only one cause Immediate Cause (Final disease or condition		brot	c Card	iovasc.	who D	560	150	Onset and Death	
	/Medical	П	regulting in death)	oue to (or as a consequ		Contract			200		/	
	Examiner	<u>~</u>	Se uentially list conditions, b.	oue to (of as a consequ	ienco ofi.							_
	nted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		,							
'n	execu an and rial-tra	Еха	that initiated events c resulting in death) Last	Oue to (or as a consequ	ience of):							
08/PN	ficate be executed g physician and st the burial-transit	edical	d							i		_
T	certific ding p		IF FEMALE: 23c. If y	es, outcome pf pregna	ncy				2	3d. Date of del	ivery	
O. BOX	w requires that the death certil been signed by the attending should be detached for use a	Physician/M	in the past 12 months?	□Live birth 2 □ Feta □Pregnant at time of d □Unknown	Ideath 3	□Ectopic pregnanc □ Other <i>(specify)</i> _				Month	Day Year	
νį.	ss that t	by Ph	Part II. Other significant conditions contributi	ng to death but not resu	ulting in the u	underlying cause giv	en in Part I.		,		the cause of death?	
ecords,	equire							10	Yes 2		robably 4 Unknown	
r	stcian: The law r certificate has be rector, page 2 sh	Completed						24a. Was auto perf 1∐ Yes		24b. Were au prior to death? 1 □ Yes	utopsy findings available completion of cause of	
Ľa	ystcian: is certifica director, p	BeC	25. Was case referred to medical examiner?			1		ath (Check only	one)			_
٥ د	S S	은	1 Yes 2 No Hospita	1 Inpatient 2	ER/Outpatie		4 🗆 Nursing	Home 5 ☐ Res			cify)	_
	ding h. Afte fune	tion:	1 Natural 5 ☐ Pending	n. Date of Injury (Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	200. Describe	now injury	Coodined		
DIVISION	or Attending after death. Director: After in by the fune	Certification:	Z Accident	Place of injury - At he building, etc. (Specif	ome, farm, s	treet, factory, office		28f. Location City or To	(Street and wn, State)	d Number or R	ural Route Number,	
	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier Check only one) Continue 2 Medical Examiner: Cartifying Physician 2 Medical Examiner: Cartifying Physician Cartifying Ph	: To the best of my kno on the basis of examina and manner stated.	wledge, dea	ath occurred at the tinvestigation, in my	me, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner a	s stated. e to the cause(s)	_
	Fo the within 2 Fo the Somple	Mec	29b. Signature and title of certifier			29c. Licens	se number		29d. Dat	e signed (Mon.	th, Day, Year)	_
ì	->-0		1 Alan Kalina	MDD	MI	D=	37197	7	Apr	11 9,	2007	
			30. Name and address of person who complet	ed cause of death (Iten	n 23a) (Type	Print)	6	15		. 171) = ===================================	
ئ	H12+1		Alan Kohrer, N	100ME 32. Registrar's Signa	5 h	est/-	Stree 1	Frede	Vi60	K /11	121101	_
	St	ate	31. Date filed (Month, Day, Year)	oz. negistrar s olgna	A /	hacks .		<i>12</i>				

APR 1 U 2007 | January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** SHAFFER 11:26 P[™] EDITH APRIL HELEN 8 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL WASHINGTON HAGERSTOWN If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Yrs. 82 219-20-1224 Director 31. 1925 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 🛛 No Director MARYLAND WASHINGTON KEEDYSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4023 TREGO ROAD 21756 Funeral U.S.A.
Race - American Indian,
Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OTIS RUSSELL LONG ESTHER IRENE ROWLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 THOMPSON LANE, CHAMBERSBURG, PA GEORGE F. SHAFFER JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 N Removal from State 4 Donation 5 ☐ Other (Specify) 4/12/2007 BOONSBORO CEMETERY BOONSBORO, MARYLAND 22. Name and Address of Facility
BAST FUNERAL HOME 21. Signature of 7606 Old National Pike Paul M. Dean Boonsboro, Maryland 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Frating Peur Fracts **Physician** Complications Secondar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No F.br.llat 24a. Was an Sec autopsy perform Hypr.ft...: 25. Was case referred to medical examiner? or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation MARCH 8, 2007 1200 PM 1 ☐ Yes > No FALL 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide | Keed | 4035 Thesa Red Keed | 1 | 1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

J5H-10

State Registrar

31. Date filed (Month, Day, Year)

Kota

Done, wo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 251

32. Registrar's Signature

5. A-+: ++

DOUSLA65

APRIL 10, 1007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Startzman Eddie 2007 Kobert tori /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 52 220-58-4268 06/21/1954 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Items 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 X No MD Washington Hagerstown Director 10e. Street and Number 1222 W. Washington Street 10f. Zip Code 21740 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White ģ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Freight Dock Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Levenia Agnus Pilgrim Robert Eddie Startzman, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 W. Washington Street, Hagerstown, MD 21740 nt of Health a : If Item 27 is or other trai Lisa C. Startzman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 04/11/2007 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner burial-trai Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed TOBACCO USE 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

certificate be executed and O. Box 68760. physician attending philosopher of the second the þ Division or Vital Records, P. signed I has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funerel director, p

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

5H-10

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 1 0 2007

S'AMUEL

29b. Signature and title of certifier

RAO , M. () 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

322 E. Antietam Street, Hagerstown, MD 21740

29c. License number

D0051282

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 01, 2007 1:55a A Betty Smith April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Hours Yrs Director Maryland 58 9/08/1948 213-56-6606 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifiled at X Yes 2 □ No Director Charles Waldorf Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2920 Hadley Drive 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sams Club Demo Associate permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 is marked other th any Injury or other traumatic event, the other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Duckett 2 Herman Smith Gladys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Adams Lane Waldorf, Maryland 20602 Tina Watters/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Asbury Church 4/7/2007 Brandywine, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature peral Service Licensee 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCIARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by

Examiner requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

page 2 funeral director this n 24 hours after death.

or Attending

Hospital

Be

Certification: To

179 ren	MARKIEWSIN							1 Yes 2 No 3 Probably 4 Unknown			
				-			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case refer examiner? 1 ☑ res 2 ☐	1	Hospital: 1 ☐ Inpatient 2 [ZER/Outpatient 3[] DOA	Other		h (Check only one) ome 5 ☐ Residence 6	5 □Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati			28b. Time of Injury M		Injury at Work? 1 ☐ Yes		28d. Describe how injury	y occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		home, farm, street, fa	ictory, o	ffice		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)			
29a. Certifier	1 Certifying Ph	nysician: To the best of my kr	nowledge, death occu	irred at	the time. d	ate and place.	and due to the cause(s)	and manner as stated.			

(Check only

1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D40324 29d. Date signed (Month, Day, Year) APRIL 2, 2007

20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 SUKRATTS ROAD, CLINTON, MARY LAND TERKY JODRIE, MD

31. Date filed (Month, Day, Year) APR 05 32. Renstrar's Signature

State

Registrar

completely

within 2.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Sr. 5:55 AM M James W. Smith, APRIL 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO SALISBURY WICOMICO NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 244-38-6449 78 9-19-1928 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 2119 Ruxton Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator Transportation permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဨ Ray A. Smith Blanche I. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Smith - wife 2119 Ruxton Road, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva | 4-5-07 Delmar, DE 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part . Enter the disease, or complications, or heart failure. List only on discounting that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA Physician /Medical Examiner Sequentially list conditions, if any teacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of) Examiner certificate be executed Due to (or as a consequence of) physician a Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 2 □ No ed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Records, ş 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed DISTASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Jas autopsy performed page certificate 2⊠ No Division or Vital 1□ Yes 🖫 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) AZ No 1 ☐ Yes 1 Inpatient မ 2 ER/Outpatient 3□ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Accident Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗜 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Easternshore Dr Salisbury MD 21804 Maesha Thimmarayappa M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5 Per FH G867 5/24/07 JH Contificate of Decay. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 38 FM **Physician** 07 Vanessa Ann Shocklev /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Kacional Medica rear If Under 24 Hrs. 216-70-7372^{mber} Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 219-60-0722 48 Dec 18, 1958 MĎ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Worcester Whaleyville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n. 21872 USA 8534 Whaleyville Rd. Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black Specify Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fulton Shockley, Sr. Phyllis Showell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8534 Whaleyville Rd., Whaleyville, MD 21872 Phyllis Shockley/mother Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \(\overline{\text{PBurial}} \) 2 \(\overline{\text{Cremation}} \) 3 \(\overline{\text{Removal from State}} \) 4 \(\overline{\text{Donation}} \) 5 \(\overline{\text{Other}} \) (Specify) Pulletts UMC Cemetery 4/3/2007 Whaleyville, MD 21. Signature of Funeral Service Lights e 22. Name and Address of Facility Lewis N. Watson Funeral Home alaxa HValso A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monar hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 1 | Yes 2 | No 3 | Probably 4 | Junknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? certificate 2 ☑ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hosnital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 10 Inpatient 2 ER/Outpatient 3 DOA 2 completely filled in by the funeral 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death. 7 To the Funeral Director: A death. 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD ost Carroll St

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day,

Shockle

nessa

ORIGINAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

12

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

Brian M. O'Connor, M.D., 501 West Seventh Street, Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

APR 1 8 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1, per PHYS., G866, 4/18/07 WS #5, per FH2

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last Estalene 2. Date of Death 3. Time of Death P. Strait Month 3 Year 07 **Physician**)tract 7:45 PM /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore marland verview 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗌 M 10-61-1921 McConnellsburg, PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ▼ Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 420 Virginia Ave. 21221 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Factory 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert F. Lake 2 Grace A. Steach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Lake 420 Virginia Ave. Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Siloam Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3-28-07 Harrisonville, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility -Howard L. Sipes Funeral Home ,Inc, McConnellsbur Mo1035 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ND STAGE CONGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 X Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was aก page 2 : certificate has autopsy performed' 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Thursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 □ Naturai 2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29d. Date signed (Month, Day, Year) 29c. License number a sille MD of person who completed cause of death (Item 23a) (Type, Print) Place Dundalk MD 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 020 AM Month **Physician** teles 2007 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Solomens Edgewater

If Under 1 Year | If Under 24 Hrs. Island tme 2665 8. Date of Birth (Month, Day, Year) 12/18/1934 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Maryland 1 □ M 2 🔀 F 219-30-4973 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Industrial. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√∑ No MD Anne Arundel Edgewater Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21037 USA 2665 Solomons Island Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married XX Married Specify: White 1 ☐ Yes 2000No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Griffith James Samuel Coale ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Albert R. Toft Husband 4082 Muddy Creek Rd. Harwood, MD 20776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Zion U.M. Cemetery 4/2/2007 Lothian, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Furth at Service Lic 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lance disease or condition resulting in death) MS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Minknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy perform 1∐ Yes 2 **Z** No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) * APR 0 3 2007

pron who completed cause of death (Item 23a) (Type, Print)

900 Besty
32 Registrar's Signature

D0064379

Sute 300 Amapalus

State

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:36 A M James E. Thompson 29 2007 March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 X M 2 □ F 218-26-8261 79 Feb. 4, 1928 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County 28a-f show Severna Park 1 ☐ Yes 2 No Maryland Anne Arundel notified Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 21146 U.S.A. 318 Hollyberry Road Depariment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examilner must to once. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1**XX**es 2 □ No If Yes, Give Year or Dates: 1948-50 1 ☐ Never Married 2XXMarried White 1 ☐ Yes 2**KM**o Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Frank H. Thompson, Jr. Edna Spear မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Hollyberry Road Severna Park, Maryland 21146 Joan Thompson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Bluff Cemetery | 4/3/2007 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur Ameral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocar minutes **Physician** /Medical Due to (or as a cons-quence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BYOMEN Due to for as a consequence of Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as) attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Honknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 res 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🔲 Inpatient 2 □ PR/Outpatient 3 □ DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -haton45 APR 0 2 200 31. Date filed (Month, State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3 200 Facility Name (If not institution, give street and number) 0 em /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Koglind M · Comuco kdical (Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number **Funeral** Days 228-42-692 Usual Residence of Decedent 1 ☐ M 2 🖫 F Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inopartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Completed by Funeral Director CESS GNN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 20 No Baltimore, Maryland 21215-0036 1 ☐ Yes 3 Widowed 4 Divorced 0 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) ambe erator Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) grand 20c. Location - City or Town, State Scar porough dan 20a. Method of Disposition OhNSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Acres Cen 4-22. Name and Address of Facility & 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immiscillate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fire a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 1 Tyes 2 □ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No After this certificate Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ D0A Inpatient ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-1-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CAKROLI M.D. J. Taylor 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		-	1 - Stata Registrar			Cer	tificate	of Dea	ath		Reg. No.			
	first.	4	Decedent's Name (First, Middle, La	st)						2. Date of D		V	3. Time o	f Death
ľ	Physici		Lily Eskola	Van Ho	esen					Month	30 -		12:50	\mathbf{p} M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, To	wn, or Loca	tion of Death	IMICII		County of Death		
1	Examin	e (6605 100th Aver				Cash	1-			D			
		A 20			ige (In yrs. /a.	st birthday)	Seabr If Under 1		nder 24 Hrs.	8. Date of B	irth	ince Ge	orges iplace (State i untry)	or Foreign
- 6	Funeral Director			1 □ M 2 🕱 F	82	Yrs.	Months (Days Ho	urs Min.	07/10			intry) nesota	
	D		Usual Residence of Decedent											
	ylan		10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside C	_
	Mar -fel	to	MD Prince (eorges	Sea	brook							1 X Yes	2 No
	286 r	Director	10e. Street and Number			<u> </u>	10f. Zip C	ode			10g. Citi:	zen of Whai Co	untry?	
	3a o		6605 100th Avenue	•			20	706			11	SA		
	ns 2	Funeral	11. Marital Status	12. Was Deceden		. 13. V	Vas Decede	nt of Hispani	c Origin? (Spe	ecify Yes or N		14. Race - Amer		
10	Iter c	Ξ	1 Never Married 2 Married	Armed Forces					xican, Puerto	Hican, etc.)		Black, White	, etc.	
33	Irs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:	1	∏Yes 2	No Spe	ecify:			Specify:	hite	
ŏ	72 hours after death with the Maryland netural; or Items 23a or 28a-f ehow dical Examinar must be notified at	ed	15. Decedent's E			16a. Deced	lent's Usual (Occupation			16b. Kii	nd of Business/I		
15	in 7	pie	(Specify only highest gr		(F .)	(Give i	kind of work DO NOT use	done during retired)	most of work	ing	U.S.	Depart	ment o	f
21215-0036	iene.	Completed	Elementary/Secondary (0-12) 12	College (1-4o	5+)	Edit	or					Medica		
	Hyg othe	0	17. Father's Name (First, Middle, Las	')				18. N	Nother's Name	e (First, Middle				
lan	lid be lental ked ic ev	To B	Walford Eskola					Ту	yme Was	stin Sa	alo			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If Item 27 is marked other than "netural", or Items 23a or 28a-f ehow or other traumatic event, Ita Madical Examiner must be notified at		19a, Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street and N	umber or Rura	al Route Numi	ber, City or	r Town, State, Z	ip Code)	
	and 2 lealth (m 27 I		Norman R. Van Ho	esen / Spo	ouse	6605	100th	Avenu	e Seab	rook, l	MD 20	706		
ē,	s 1 a f He ffem othe		20a. Method of Disposition		20b. Pla	ce of Dispos	silion (Name	of		Date		cation - City or	Town, State	
Ĕ	Pages nent of I ant: If Its ary or o		1 ■ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci		6		oln Ce	, ,	04/04	/2007	Brer	ntwood,	MD	
Baltimore,	그 본 관 중 .		21. Signature of Funeral Service Lice	nsee	.0	22	. Name and	Address of F	acility					
ä	Department of the partment of		Joya Montgom	eres-Ches	Han	Ft	t. Lin	coln l	Funeral	Home,	Inc.	d MD	20772	
	#P ()	1	23a, Part 1. Enter the disease, or con	plications that cause	ed the death.							<u> </u>	Approxima	
	An The		shock, or heart failure. List only Immediate Cause (Final										Onset and Mon	Death
	Physician /Medical		disease or condition resulting in death)	a	noma Of		Duodei	ium					J MOII	LIIS
	Examiner			Due to (or a	is a conseque	ence of):								
(85)		-	Sequentially list conditions,	b. Due to (or a	is a conseque	ence of):								
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,									
_	and I-trar	хап	that initiated events resulting in death) Last	c Due to (or a	is a conseque	ence of):								
9	be e ician buria	E		•	,	,								
68760,	ires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Medicai		d										
×	ding se as	Me	IF FEMALE:	23c. If yes, outcom	ne of pregnan	CV						20d D-11 d-1		
Bo	death c le attend ed for us	lan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	2 Fetal o	death 3	Ectopic pred				- 1	23d. Date of deli Month	Day	Year
o.	the d	Physician	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	9□ Unknown		atti 5	Tottiel (spec	y)						
<u>α</u>	The law requires that the site has been signed by the bage 2 should be detache	F	Part II. Other significant conditions	contributing to death	but not resul	ting in the ur	nderlying cau	ise given in I	Part I	23e. Did	tobacco u	ise contribute to	the cause of	death?
Records,	signe bed I	þ	, <u></u> ,					J. J		1 [Yes 2	XNo 3□Pr	obably 4	TUnknown
0	w require been si should	Completed												
ec	elaw hasb je2si	힐								24a. Wa aut	opsy	24b. Were au	topsy findings completion of	available cause of
<u> </u>	The ate h	5									formed? 2 No	death?	2□ No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?						Place of Deat	h (Check only	one)			
of \	hysic his co	၉	1 ☐ Yes 2 🏝 No	Hospital: 1 Inpa		R/Outpatien	t 3 DOA	Other: 4	☐ Nursing Ho	me 5 Re	sidence (6 □Other (Spec	cify)	
	fter fter		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, D	jury Day Year)	28b. Time of Injury	280	:. Injury at Work?		28d. Describe	how injur	y occurred		
0.0	Attending r death. sctor: Attention	ati	2 Accident investigation	on			М	1 🗌 Yes	2 🗆 No					
Division	r Att ter de rectu	tiffe	3 ☐ Suicide 6 ☐ Could not determined	28e. Flace of i	njury - At honetc. (Specify)	ne, farm, str	eet, factory,	office			(Street an	d Number or Ru	ıral Route Nui	mber,
	ital o rs aft al Di	Certification:												
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			hysician: To the bearing										(s)
	the H in 24 the F iplete	Medical	one)	and manner	stated.	on anator in	- Josephan (OI), II	. my opinior	, domin occum	. Se at the title				
	With To 1	Σ	29b. Signature and title of certifier				29c.	License num	nber		29d. Dat	te signed (Monti	h. Day, Year)	

23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No d? No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) April 2, 2007 7500 Greenway Center Dr. #430 Greenbelt, MD

State Registrar

1 State

31. Date filed (Month, Day, Year) APR 03 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D37934

		State of Maryland, Department of Health and Mental Hygiene 1 - State Registrar Amend #17x18 Per Phy &FH G867 Certificate of Death Reg. No. 2 Date of Death 3 Time of Death
Physicia /Medic	an	Joseph F. Velenovsky, Jr. O4 03 2007 0100 M
Examin	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Scalisbury 4c. County of Death Wicomico
Funeral Director		5. Social Security Number 212-26-7945 6. Sex 7. Age (In yrs. last birthday) 81 Yrs. 1f Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1/16/1926 9. Birthplace (State or Foreign Country) Maryland
rf show fied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester Ocean City 1 □ Yes 2 □ Xo
23a or 28a st be not	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA
tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: White
ne. han "natura e Medical E:	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Manager/butcher Food Service
ntal Hygier ed other th event, the	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
th and Mental 7 Is marked o traumatic eve	<u>م</u>	Joseph F. Velenovsky, SR. Anna M. Casper Raspan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15abelle E. Velenovsky/wife 606 141st. Street, Ocean City, MD 21842
nent of Health int: If item 27 I iry or other tra		20a. Method of Disposition 1 Derivation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cematory or other place) Springhil Memory Gardens 20c. Location - City or Town, State 4/10/07 Hebron, MD
Department Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804
ysician Medical		23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a co sequence of):
ite has been signed by the attending physician and soage 2 should be detached for use as the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d
attending propertion of the second se	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)
s been signed by the signal should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Alo 3 Probably 4 Unknow
S C/1	Completed	24a. Was an autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 No
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1
within 24 hours after death. To the Funeral Director: A completely filled in by the f	Certification:	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
n 24 hours h e Funer a pletely fille	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 - 3 - 07
5 mp		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David E. Carell, MD Granted Hispire Pu Box 1733 Salish, MD 21802
St Regist	ate	31. Date filed (Month, Day, Year) APR 0 5 2007

		1	For State Registrar	te of Maryla		rtment of H		Mental Hygid	ene 007	12523
	Dhumini	_	I. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	
	Physicia /Medic	al -	Eunice Rose Ward						28 200 4c. County of D	
	Examin	er	ia. Facility Name (If not institution, give street a William Hill Manor				Easton			Talbot
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 23		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Nov. 15,	1924 9.1	Birthplace (State or Foreign Country) Virginía
	and I	1	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	to	Maryland Talbot			East	on			1 ☐ Yes 🏖 📆 No
	with the 3a or 28a	i Director	10e. Street and Number 29746 Tracey's Way			10f. Zip Code	21601	10	g. Citizen of What U.S.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants: If item 27 is marked other then "natural", or items 23a or 28a-f show says injury or other traumatic event, I'm Medical Engliner must be notified at ancie.	by Fur	1 Never Married 2 Married	s Decedent Ever in the second Forces? Yes ANO es, Give ar or Dates:	'	Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		merican Indian, Thite, etc. White
21215-0036	n 72 ho "natur rollcul	Completed	15. Decedent's Education (Specify only highest grade comp		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking 1	6b. Kind of Busine	ess/Industry
712	iene.	ошо	Elementary/Secondary (0-12) Co	lege (1-4or 5+)		eckout Cl	*		Grocer	y Store
and	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Stephen Whitby					me (First, Middle, M Fuqua	aiden Sumame)	
Maryland	nd 2 shou lith and M 27 is mar r traumati	-	19a. Informant's Name/Relationship (Type, Pr. Larry Ward/son	nt)		ng Address (Street 5 Tracey		ural Route Number, laston, Ma		te, Zip Code) 21601
nore,	ages 1 ar int of Hea t: If item 3		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Remova 1 ☑ Donation 5 □ Other (Specify)	I from State		natory or other pla	rdens 4/		oc. Location - City	or Town, State Maryland
Baltimore,	permit. P Departme Importen eny injur.		21. Signatur Fureral Service Licensee	J-10	7 22	2. Name and Addre	ss of Facility Jo	hn M. Tay	lor Fune	
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	s that caused the se on each line.	death. Do not ent					Approximate Interval Between Onset and Death
8760,	death certificate be executed be attending physician and ad for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a cor		UNKAD	end o	rjem		3 Ulcr
.O. Box 6	eath certifi attending for use as	Physician/Mec	in the past 12 months?	res, outcome of pr Live birth 2 Pregnant at time Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	y n		23d. Date o Month	f delivery Day Year
<u>α</u>	uires that the d n signed by the	by	Part II. Other significant conditions contribut	ng to death but no	t resulting in the u	inderlying cause gi	ven in Part I.			ite to the cause of death? Probably 4 Dunknown
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed				8		24a. Was ar autops perform 1 Yes 2	y prio ned? dea	re autopsy findings available r to completion of cause of th?
ital	10	BeC	25. Was case referred to medical examiner?					ath (Check only on	9)	
of <	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospita	1 L Inpatient	2 ER/Outpatie	nt 3 DOA		Home 5 Reside	ence 6 Other ((Specify)
	ing After fune	tion	27. Manner eath 1 Patural 5 Pending 2 Accident investigation	i. Date of Injury (Month, Day Ye		Wo	ork?]Yes 2∐No	200. 2000	,,	
Division	of or Attendia after death. I Director: At d in by the fu	Certification:	© Could not be	Place of Injury - building, etc. (S		reet, factory, office		28f. Location (St. City or Town	reet and Number (n, State)	or Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 2	To the best of mention the basis of exa	y knowledge, deat mination and/or in	th occurred at the tovestigation, in my	ime, date and plac opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
\		Me	29b. Signature and title of certifier	3 m	D	29c. Licen	se number	2	9d. Date signed (/	Month, Day, Year)
	(3)		30. Name and address of person who complete	ed cause of death	(Item 23a) (Type					
			Dr. William Wood, J.			s Lane E	Caston, M	D 21639		
	Sta Regíst	ate rar	31. Date filed (Month, Day, Year) APR 0 2 200	32. Registrar's	Signature	books				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5:06 A M 2007 Shelby Beatrice Washington March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2 🐼 F 83 579-44-0178 June 4 1923 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County No Yes 2 No Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1809 Ironton Drive 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Owens Alzerah Cowens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Washington/Husband 1809 Ironton Drive, Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection April 4 2007 Clinton, Maryland 22. Name and Address of Facility 5538 Marlboro Pike 21. Signature of Funeral Service Licensee Pope Funeral Home, P.A. Forestville, MD 20747 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or constance, or heart failure. List only Immediate Cause (Final 1 Cemia disease or condition resulting in death) Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed bunial-tran attending physician for use as the buria ned by the a the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

\$

Completed

Be

¹

Certification:

Medical

Physician

Examiner

Funeral

Director

an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be na gines.

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

Director

9

Completed

Be

ျ

/Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 03 2007

29b. Signature and title of certifier

4 Homicide

Richard

29a. Certifier



MI

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

almer

determined

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0055120

SE Junto 310

29d. Date signed (Month. Dav. Year)

March 27.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** APRIL 2007 12:45PM™ VERNON RUSSELL WHITELY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENESIS HEALTHCARE - THE PINES EASTON TALBOT tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1**X**M 2□F 96 OCTOBER 9, 1910 MARYLAND Yrs Director 216-05-1322 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **EASTON** Director TALBOT MD Department of Health and Montal Hygiene.

Important: if item 27 is marked other then "neturel", or items 23a or 28e-f. Important: if item 27 is marked other then "neturel", or items 23a or 28e-f. any injury or other treumatic event, the Medical Examiner must be notified any once. 10e Street and Number 10f Zin Code 10g. Citizen of What Country? WIT 610 DUTCHMANS LANE 21601 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No
If Yes, Give
Year or Dates: 1939-1945 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: À 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 8 0 ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be HATTIE ANN GOODMAN F. FRANK WHITELY ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY W. SPICER/DAUGHTER 29495 HAWKES HILL ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BELMONT CEMETERY 4/4/2007 CHOPTANK. MD 21. Signature of Funeral Service Licensee C. 6.5P FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ustrough 200 S. HARRISON ST. EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat mounomin **Physician** disease or condition resulting in death) /Medical Examiner 1 ars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificete be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical tF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, themoloustopenic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 No 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Naturat 1 ☐ Yes 2 ☐ No death Director: , 2 Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Ptace of Injury - At home, larm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours aff To the Funeref Di completely filled in the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) MD

ROWKE

2007

DUTCHMANS

610

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			For State State Registrar	ate of Maryland		rtment of Hea tificate of De			iene 007	12526
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	D V	3. Time of Death
	Physicia /Medic		JAMES HANNON WILLETT	, JR.				APRIL 3	, 2007	8:30 PM
	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or Lo			4c. County of Dea	
			CIVISTA MEDICAL CENT	T. Age (In yrs. la	ot hirthday)	LA PLATA		8 Date of Birth	CHARLES	
	Funeral Director		5. Social Security Number 6. Sex XXM 2		Yrs.		Hours Min.	8. Date of Birth (Month, Day, DEC 22,	1932 WAS	thplace (State or Foreign ountry) HINGTON DC
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	e Mai	Director	MARYLAND CHARLES		NAN	JEMOY				1 ☐ Yes 2X No
	or 26	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
	ath w		5235 PORT TOBACCO ROA		10.11		662	acify Ves or No-	UNITED ST	
36	d within 72 hours after death with the Maryland jene. Ir then "natural", or Iteme 23e or 28e-f show The Mudical Examination out the motified at	by Funerai	Ar	as Decedent Ever in U.S med Forces? ŽYes 2 □ No 195 Yes, Give ear or Dates: 195	3-	Vas Decedent of Hispa i Yes, specify Cuban, I	Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
21215-0036	2 hou		15. Decedent's Education (Specify only highest grade com	n(eted)	16a. Deced	lent's Usual Occupatio	on ina most of worki	ina	16b. Kind of Business	s/Industry
215	within 7 ene. then "r	Completed		ollege (1-4or 5+)	life. L	kind of work done duri OO NOT use retired)	ang most of month		WASHINGTON	
	filed with Hygien wither the		12 17. Father's Name (First, Middle, Last)			CARPENTER	Mathor's Name		GOVERNMENT Maiden Sumame)	
Maryland	od ital	Be	JAMES HANNON WILLETT					EN ELAIN		
Ž	should be and Mental I marked o	은	19a. Informant's Name/Relationship (Type, Pl	rint)	19b. Mailin	g Address (Street and			. City or Town, State,	Zip Code)
Z	0 6 6 5		JOHN A. WILLETT - SON						OY, MD 206	
altimore,	ages 1 and 2 int of Health It: If item 27 I y or other tre	13	20a. Method of Disposition 1 ☐ Burial ②XCremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	metery, cren	sition (Name of natory or other place) REMATORY	APRÍ	ىل.	20c. Location - City of WALDORF, M	
Baltir	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Joensee) M00053	22	. Name and Address of	of Facility HU	NTT FUN	ERAL HOME	
	Q □ 72 42 04		23a. Part1. Enter the disease, or complication	named the death					ALDORF, MD	Approximate
	Physician /Medical	jė į	shock, or heart failure. List only one car Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ic	Prosta				Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, b. b.	Due to (or as a consequ	ence of):					=======================================
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
0,	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	cate b	edicai	d							
Box.	ath certifi attending for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnar □Live birth 2 □Fetal □Pregnant at time of de □Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
s, P.O.	res that the de signed by the a be detached to	by Ph	Part II. Other significant conditions contribu	ting to death but not resu	lting in the u	nderlying cause given	in Part I.			to the cause of death?
ord	w requir been si should I									Probably 4 Unknown
I Records,		Completed						24a. Was a autop: perfor 1 Tes	sy prior to	
of Vital	cien; entific ector,	Be	25. Was case referred to medical examiner?	int:		Othor	6. Place of Deat			
of	Physi this o	٦.	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time of		4 Nursing Ho		ence 6 Other (Sp ow injury occurred	ecify)
	ding Physi h. After this o funeral dire	tion	in a contraction to the contract	la. Date of Injury (Month, Day Year)	Injury	Work?	s 2 No	200. 200050 1.		
Division	death death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	le. Place of Injury - At ho	me, farm, str				Street and Number or F	Rural Route Number,
Ο	el or / s after of Dire	Certification:	4 Homicide	building, etc. (Specify)		1	City or Tow	n, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	n: To the best of my known the basis of examinate manner stated.	wledge, death ion and/or in	h occurred at the time, vestigation, in my opin	, date and place, nion, death occur	and due to the o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	11		29c. License n	number	2	29d. Date signed (Mor	
			Humas	Turing		10005	2719		4-4-0	
1	18681		30. Name and address of person who comple	red cause of death (Item	23a) (Type,	ennial:	St. Ste 1	oz La	Plata,	MD 20146
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2007	32. Bigistrar's Signal	b A	berk				
		_								

Jamas Willett

Reg. No/007-2007 4c. County of Death BALTIMORE CITY Birthplace (State or Foreign
Country) 1943 ILLÍNOIS 10d. Inside City Limits 1 ☐ Yes 2 No 10g, Citizen of What Country? USA 14. Race - American Indian Black White etc. Specify: WHITE 16b. Kind of Business/Industry RETAIL 18. Mother's Name (First, Middle, Maiden Surname) MICHALAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11077 ST. MARTIN'S NECK RD., BISHOPVILLE, MD 21813 20c. Location - City or Town, State DELMAR, DELAWARE HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 1.5 months 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: 28d. Describe how injury occurred 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical Doctor pril 2,200+ Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital 401 Novih Broodway Baltimore Maryland 21231 31. Date filed (Month, Day, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

UN

Piney Branch Road Silver Spring Funeral Director Social Security Number S. Social	3. Time of Death
Physician/ edical Examiner 1. Decedent's Name (First, Middle, Last) Oscar Armando Velasquez Zelaya 1. Decedent's Name (First, Middle, Last) Oscar Armando Velasquez Zelaya Silver Spring Funeral Director F	3. Time of Death 0145 hrs
Scar Armando Velasquez Zelaya March 25,200 Ma	07 0145 hrs
Piney Branch Road Silver Spring Funeral Director Social Security Number S. Social	4c. County of Death
Funeral Director Social Security Number S. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM None 1½ M 2 F 27 Yrs. Months Days Hours Min. 07/30/1	Montgomery
None 1½ M 2 F 27 Yrs Months Days Hours Min. 07/30/13	M/DD/YYYY) 9. Birthplace (State or
The state of the s	Foreign
The state of Date of D	1979 Country) Hondura
The standard of the standard o	10d. Inside City Limits
The standard of the standard o	1 X Yes 2 No
The standard of the standard o	itizen of What Country?
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	onduras
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	14. Race - American Indian, 8lack, White, etc.
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	Specify: Hispanic
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	. Kind of Business/Industry
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	Construction
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State General Cemetery 04/06/07 I 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 22. Name and Address of Facility Murray Fundamental Service Licensee 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shall the service Licensee or condition resulting in death) 25b. Place of Disposition (Name of cemetery, crematory or other place) 3 Ceneral Cemetery 04/06/07 II 4 Donation 5 Other Specify 22c. Name and Address of Facility Murray Fundamental Service Licensee 22d. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Name and Address of Facility Murray Fundamental Service Licensee 25c. Na	
Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Due to (or as a consequence of):	ttsville Md 2078:
Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Due to (or as a consequence of):	c. Location - City or Town, State
Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Due to (or as a consequence of):	Honduras
Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line. Due to (or as a consequence of):	neral Home 4804
failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions.	ton DC 20011 hock, or heart Approximate Interval
or condition resulting in death) Due to (or as a consequence of): Seguentially list conditions. b.	Between Onset and Death
Sequentially list conditions.	
if any, leading to immediate Due to (or as a consequence of):	
C.	
events resulting in death) Last Due to (or as a consequence of):	
	23d. Date of delivery
2 So If yes, ductine of pregnanty 2 So. If yes, ductine of pregnanty 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
O9 X 95 And Suppose the past 12 months? IF FEMALE: 23b. Was decedent pregnant in the past 12 months? If Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
O to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	co use contribute to the cause of death?
O de training to death but not resulting in the didentifing cause given in Part i.	No 3 Probably 4 Unknown
24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The law require ficate has been signatured. The law require authors of page 2 should be a signature authors of page 1. The law requirements of page 2 should be a signature authors of page 2. Should be a signature authors of page 3. Should b	
The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital 1 ✓ Yes 2 1 1 ✓ Yes 3 1 ✓ Yes 4 1 ✓ Yes 5 1 ✓ Yes 5 1 ✓ Yes 5 1 ✓ Yes 5 1 ✓ Yes 6 7 ✓ Yes 7 ✓ Y	
25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residue (Mooth, Pay Year) 27. Manner of Death 28a. Date of Injury (Mooth, Pay Year)	idence 6 🗸 Other: Scene
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in Mar 25, 2007 0125 hrs 1 Yes 2 No	injury occurred d object collision
To be the state of	et and Number or Rural Route Number, City
O see the state of the state o	
Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the course of the cour	and manner as stated.
The standard of the standard o	place, and due to the cause(s)
29c. License number	d. Date signed (Month, Day, Year)
ME (aral Hallan O.C.M.E. ME	larch 25, 2007
30. Name and address of person who completed cause of death (Item 23a)	
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year) Registrar APR 0.3 2007	

ype or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#26, per PHYS., G866, 4/19/07, WS State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 55 AM **Physician** HRENA 0 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 100 Mexicy Med Piner 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 218-48-2677 6. Sex **Funeral** 1 □ M 2 🕱 F Yrs. West May 08,1907 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Me Teal Examines. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Mayes 2 □ No Director N/A **Baltimore** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 13 East Poultney Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Circusto Illario Roccisano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Shepherd Court, Jarrettsville, Maryland 21084 Elizabeth A. Klein (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Most Holy Redeemer 04-21-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230 Approximate Interval Between Onset and Death 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASC V Unkopu **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 2 7 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 The Stdence 6 Other (Specify) 1 Yes 2 No 2 FR/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death

1 ■ Natural

2 □ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 40166. 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) ersch MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 19 2007 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment rtificate			and Me		giene (Reg. No.	007	12530
9	Physici	an	1. Decedent's Name (First, Middle, Last) Russell Daniel Bozman 2. Date of Death Month Day Year April 18. 2007								3. Time of Death			
	/Media	cal	KUSSELL 4a. Facility Name (If not instituti				4h City T	April 18, 2007 1 4b. City, Town, or Location of Death 4c. County of Death					12:59 A ^M	
	Examir	ner	Carroll Hos						inst				arro1	
	Funeral	44	5. Social Security Number	6. Sex 7.	Age (In yrs. I	last birthday)	If Under 1	1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h	9. Birt	hplace (State or Foreign untry)
	Director		213-05-8571	X1X M 2□ F	91	Yrs.	Months	Days	Hours	Min.	April 4	4,19		ryland
	and		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City	y, Town or Lo	cation					10d. Inside City Limits		
	Maryl	tor	MD Car	roll	1	Westm	inste	er						1 □ Yes XXNo
	r 28a	irec	10e. Street and Number				10f. Zip (Code				10g. Citize	on of What Co	untry?
	th wit	aiD	250 St. Luke				21	158				•	U.S.A	•
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show or other treumatic event, tra Medical Exercities must be rectified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma XXWidowed 4 □ Divorce	If You Give	ent Ever in U. es? □No WW II	S. 13.	Was Decede If Yes, speci 1 Yes 2	-		gin? (Spec i, Puerto F	cify Yes or No- Rican, etc.)		Black, White	
21215-0036	2 hou	ted t	15. Decede	ent's Education		16a. Dece	dent's Usual	Оссира	tion		ì	16b. Kind	d of Business/	
212	within 7; ene. than "n	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4	or 5+)	life.	kind of work DO NOT use	e retired)			ng			
	filed wit Hygien other th	Con	8			Dist	ribut							al Service
Maryland	be file ital Hy id oth	Be	17. Father's Name (First, Middle		m = n						(First, Middle,		,	
돌	should no marke umatic	To	Stanley Hargest Bozman Catherine Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town								En Cordol			
Ma	id 2 si		Anne Gardner		iah+oi									
<u>5</u>	t Heal Heal Item 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of	,	Da	acksor	20c. Loca	ation - City or	Town, State
altimore,	permit. Pages Department of Importent: if it any injury or o		XXBurial 2 Cremation 4 Donation 5 Other		ate j	^{emetery, crer} Lakev Par	iew M	emo:	ria1	4/	21/07	Sv	kesvi	11e, MD
alti	partm porte y inju		21. Signature of un ral S vic			22	Name and	Addres:	s of Facilit				ral Ch	apel P.A.
<u> </u>	8 9 E E 8	Ġr 1	fushnd farm 11605 Reisterstown Rd. Owings Mills, MD2111											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									Approximate Intervat Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	fonte	E IV	1 yoca	rd	ial	Li	n favc	tion	0	Offset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ						ticla			
		i e	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):	1 Mh	Nay	ma	ven	mila	U PE	pint	
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	Human	en terro	m							
Ó	cate be executed by sicien and the burial-transit	Exa	resulting in death) Last	Due to (or	as a consequ	uence of):								Alle Salling
8760,	ate be nysick he bu	Icai		d										
9	artifica ing pt	Med	IF FEMALE:											
P.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23	d. Date of del Month	very Day Year	
	law requires that the as been signed by th 2 should be detache	y Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								the cause of death?			
Records,	w requires that been signed to should be det	Completed by									No 3 Pr	obably 4 Unknown		
000	law re as bee 2 sho		Agov Thir n di Sin								24b. Were autopsy findings available			
Ĕ	The lay ale has page 2	E O	Perroberal arteral disease 1 yes 26											
/ita	iicien: Th certiticale rector, pag	Be	25. Was case referred to edice examiner?	-					26. Place	of Death	(Check only o			
<u>}</u>	Physicien: r this certificated fral director, i	2	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 140		ne 5 🗆 Resid			cify)
UC C	ding P	ion:	27. Manne eath 1 atural 5 Penc		Injury Day Year)	28b. Time of Injury		Work			8d. Describe h	now injury	occurred	
Division of Vital	Attending r death. ector: After by the funer	cat	3 Suicide 6 □ Coul		Unium - At ho	ome farm etr	M factory		′es 2 🗆 l		Bf Location (5	Street and	Number or Ri	iral Route Number
	al or Attend atter death Director: / d in by the f	Certification:	4 Homicide 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							and the state of t				
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely tilled in by the funeral director, page	edical C	29a. Certifier 1 ertify (Check only one) 2 Medica	ring Physician: To the basi at Examiner: On the basi and manne	is of examinal	wledge, deatl tion and/or in	n occurred a vestigation,	it the tim in my op	e, date an inion, dea	d place, a th occurre	nd due to the ed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
)	To the To the comp	We	29b. Signature and title of certification	ier Ardr	21	7	3	39		M	7	H	signed (Monti	
(Sx1		Syen S	n who completed cause	0	447	Print) , Eas	c /-	Mai	n si	Nect	West	minste	MB 21117
of the same	Sta		31. Date filed (Month, Day, Yea		jistrar's Signa	ture								
DH	Registi IMH 17 Rev 1/2		APR 1	2007	yes &	J. 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:10 p M **Physician** Hilda Ĺ. Betz April 16 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ivy Hall Nursing Center Middle River Baltimore 8. Date of Birth (Month, Day, Year) April24,1924 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 😿 F 220-14-1674 82 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No MD Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Stemmers Run Road 21221 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Secretary Baltimore County 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Schadel Anna Belle Bock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Gwaltney 3411 Yorkway Road Balto, MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Holly Hill Cemetery 4/20/07 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Pervice Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 00-1 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□A 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

burial-transit and certificate be execu Division or Vital Records, P.O. Box 68760, attending physician the as nse 10 signed by the a d be detached f page 2 s has certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this

Funeral

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

hours after

filed within 72

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Men

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

10

Registrar

State

Medical

29a, Certifier

29b. Signature and title of certifier

29c. License number

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ohh

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 18, 2007 4:10a м Marion T. Betz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ivy Hall Middle River 8. Date of Birth (Month, Day, Year) July 8, 1921 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 M 2 □ F 85 213-18-1710 Director MAryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits fshow rat", or items 23a or 28a-f shov Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21221 USA 76 Stemmers Run Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or iter any InJury or other thaumatte event, the Medical Examiner any InJury or other thaumatte event, the Medical Examiner. 1 ✓ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GM Line Worker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Fahey Andrew Betz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Yorkway Road Baltimore MD 21222 Kathleen Gwaltney /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 4/20/07 Baltimore MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Liberisee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** retrova railor disease or condition resulting in death) 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Medical 0

29a, Certifier

29b. Signature and title of certifier

APR19

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 041 J6 X/1 31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

0.0

Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Auo.

29d. Date signed (Month, Day, Year)

/Medical Examiner the burial-trans Division or Vital Records, P.O. Box 68760, attending physician death certificate be for use as ned by the at funeral director. After this al or Attending P after death. I Director: After t the To the Hospital o within 24 hours aft To the Funeral Di

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

o e

rai ; or items 23a Examiner must b

"natural

ene.

. Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked off Jury or other traumatic even

permit. Pages Department of Important: If It any Injury or c

Physician

Director

Funeral

2

Completed

Be

ပ

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be Certification: To Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 14160 April 13, 2007

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harjit Singh, M.D. 5410-A Ritchie Highway, Brooklyn Park, MD 21225

ORIGINAL

07-02938 Martin L. Bosse Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

0		17 7	1	0		3	1
1	U	07		-	J	U	i.

Projection Pro				For State				Certifi	cate of	Death					Reg. No).	UU	1 10	
State Section			n/ 1	. Decedent's Name (First, Middl	e,Last) Bos	sse								Month	Day 2007			3. Time of Death 0716 hrs	
The control of the co			4	St. Agnes Hospital Baltimore															
Usual Nacesce of December 100 Engage 1				· ·		1 2 F	ľ			-			_						and
Maryland Baltimore Catonsville Maryland Baltimore Catonsville Maryland Baltimor									um as Lagati									10d. Inside City I	Limits
The Strong and Number 216 Rolling Brook Way 2128 107.20 Company 216 Rolling Brook Way 2128 108. Strong and Number 218. Manual States 11 Newer Marrier 2 2 Manual States 12 Manual States 13 Manual States 14 Manual States 15 Manual States 16 Manual States 17 Manual States 18 Manual States 18 Manual States 19 Manual States 10 Manual States 10			- 1		imor	٠,												1 Yes 2	XNo
The continue of the continue	ryland a-f sh	t once	핡	10e. Street and Number 10f. Zip Code									10g. Citizen of What Country?			ry?			
Number Selection April A	he Ma	iffed 8	Dire	216 Rolling B	rook	Way													
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	with I	be no	eral	11. Marital Status		12. Was De		Ever in U.S.	13. Wa	s Deceden es, specify	t of Hisp Cuban,	anic Origi Mexican,	n? (Spe Puerto F	cify Yes or Rican, etc.)	No-			an Indian, Black	'
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	er deatl	must	Fu			1 X Yes		No	1	Yes 2	X No	specify:				Specify:	Whi	te	ŀ
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	urs afte	mine				or Dates:		pleted) 16	6a. Deceder	nt's Usual C	ccupation	on (Give k	ind of wo	ork done	16t	. Kind of Bu	siness/In	ndustry	
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	6 172 ho an "na	cal Ex	lete	Elementary/Secondary (0-12			(1-4 or 5							147	Ι,	Flootr	ical.		
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	003 within giene.	Medi	d Lo	17 Eather's Name (First Middle	e Last)	5+	_		Elect	rical_	Eng 1	8.Mother's	r s Name	(First, Middl					
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	215- e filed tal Hyg	th.																	
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	21; hould b	tic eve																	
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	MC sind 2 silth ar	raum	ŀ		oss		Wife	20b. Pla	ce of Dispo	sition (Nam			way		20	c. Location	- City or		
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	Nore	other		1 Burial 2 X Crematic		Removal	from Sta	ile	ro Cre	mato1	~v					atons	vill	e, MD	
Physician ledical aminor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or one cause or each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use or condition resulting in death. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use of the cause of death or conditions are constituted and provide a conditions. 25a. Part I. Enter the disease, or complications and provide and the cause of death. 25b. Due to conditions and provide and pr	altim nit. Pa partmen	iry or	ŀ	Donation 5 Other Signature of Funeral Service	specify: e Acens				22.	Name and	Address	of Facility	Ster	ling	Ash	ton So	hwal	Witzke	3
Table 1 List only one cause on each line. Table 1 List only one cause on each line. Table 2 Library one cause on each line. Table 3 Library one cause on each line. Table 3 Library one cause on each line. Table 4 Library one cause on each line. Table 5 Library one cause on each line. Table 5 Library on the cause of library one cause on each line. Table 5 Library one cause on each line. Table 6 Library one cause on each line. Table 7 Library one cause on each line. Table 8 Library one cause on each line. Table 9 Library one cause one cancer one library o				(11)	h	N	012	90	i	1630	Fdmc	nnden	n At	renne:	(.a	consv.	ште		. 2.0
The mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, leading to immediate cause. International continuous continuo				failure. List only one caus	e on ea	ch line.								,					
To the part of the										IID Vascu	ai Dio	case							
Course. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Op 269 YOR O Co Control Control					b.	Due to (or o	0 0 0000	equence of):					_		_	-			
THIS TO BE THE PROPER TO THE PROPER TO THE PROPER TO THE PROPER THE PROPER THE PROPERTY OF THE			nine	if any, leading to immediate Cause. Enter Underlying Cause Chicage or injury that initiated C.														-	
THIS TO BE THE PROPER TO THE PROPER TO THE PROPER TO THE PROPER THE PROPER THE PROPERTY OF THE	(d 3	nsit	Exar	events resulting in death) Las	t d	Due to (or a	s a cons	equence of):											
Was decedent pregnant in the past 12 months? Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions Contribute to the cause of death? I Ves 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? Yes 2 No 25. Was case referred to medical examiner? I Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death I Ves 2 No 28b. Diate of Injury at Work? 28d. Describe how injury occurred 1 Nowman of Injury at Work? 28d. Describe how injury occurred 28d. Desc	execul	ian and ial - tra	ical	UNPENDED	٦Ľ	AMENDE	D												
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	760, cate be	등원			the			me of pregna		etal danth	3	Ectopi	c pregna	ancv				•	ear
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	certifi	ending use as	cian	past 12 months?		4 Pre		t time of dea					o p. og		_				
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	Bo)	the att	hysi			0		th but not so	culting in the	underlying	Cause	given in P	art I.	23e. [Did toba	cco use cor	itribute to	the cause of de	eath?
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	P.O.	ned by detach																	
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	ds, l	een sig ould be	eted	V. 													. Were a	utopsy findings a	available ause of
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	e law r	2 7)dm												erform	ed?	death?		-
O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	al Re	rtificat tor, pa			cal						26.Plac								
O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	Vita	this ce al direc	l 0	1 ✓ Yes 2 No		· L.												er: 	
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	n of	After		1 2 National	endina	28a. D	onth, Day,		200. Time 0	ii ii ijui y		•				,,			
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	isio Atten	rector:	icati	2 Accident In	vestigat	28e. F	Place of I	Injury - At ho	me, farm, st	reet, factor	y, office	building,	etc.				nber or F	Rural Route Num	ber, City
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	Div	illed it	erti	4 Homicide	etermine	d (Spec								L.,					
29b. Signature and title of centifier O.C.M.E. April 18, 2007 30. Name and address of person who completed cause of death (Item 23a)	n 24 hc	e Fund letely f		29a. Certifier 1 Certifying	Physic	ian: To the	best of r	ny knowledg amination ar	ge, death oc	curred at th	e time, o y opinio	date and p on, death o	lace, an	d due to the at the time,	cause date ar	(s) and mani nd place, an	ner as sta d due to	ated. the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) April 18, 2007	To th within	To th	Medi	2 Medical Examiner Stated. 29b. Squartre and title of certifier. 29c. License number															
Add Dans Chant Boltimore MD 21201			_	1	1,00	1/11					O.C	M.E.				April 18,	2007		
A A A A A B - F - F	1	0			son who	completed	cause of	death (Item	23a)	0:	. Deli	imper	MD 04	201					
10 T Pagistra's Signature	10+1	\								nn Stree	t, Bait	imbre, I	VIU ZI						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar ADR 1 0 2007	R					A	e. registi	Jan 3 Signatu	Cornel	e P									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

		-	State of Maryland / Depa	rtment of Health and M tificate of Death		ne . n. 2007 12535
	Physicia		Decedent's Name (First, Middle, Last) William Edward Blankens	2. Date of Death Month	Day Year 3:00 P. M	
	/Medic	al	WITTAIL EDWARD DIAIRCES 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April	4c. County of Death
	Examin	er	Glen Burnie Health & Rehab.	Glen Burnie		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 122 30 1333 12X M 2 F 75 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 22,	ear) 9. Birthplace (State or Foreign Country) New York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Maryl i-f sho	to	Maryland Anne Arundel Glen Bu	rnie		1 ☐ Yes 2 🔼 No
	ath with the Marylan 23a or 28a-f show ust be notified at	Director	10e. Street and Number	10f. Zip Code	10g	Citizen of What Country?
	s 23s	erall	145 S. Meadow Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. V	21060	ecify Yes or No-	U.S.A. 14. Race - American Indian,
980	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show nical Exactinet roust be motified a	by Funeral	1 □ Never Married 2 Married 1 □ Yes 2 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto 口 Yes 2图 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
21215-0036	C 2	Completed	(Specify only highest grade completed) (Give life. [ent's Usual Occupation kind of work done during most of worki DO NOT use retired) in Operator	ing 16	Eb. Kind of Business/Industry Construction
1d 2	Hyc Hyc	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Surname)
ylar		ToE	Edward Blankenship		Lieberman	
Maryland	12 sh h and 7 Is m traum		, , , , ,	g Address (Street and Number or Rura 5. Meadow Drive		nie, Maryland 21060
Baltimore,	of of			natory or other place)		altimore, Maryland
Balti	permit. Pag Department Importent: I any injury o once.			. Name and Address of Facility Go 1001 Ritchie Highwa		ral Service, P.A. nore, Maryland 21225
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a	SPIRATORY	FAILUI	
	Examiner		BUATINA	- PNEUMON	VIA	
	ed .	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-11	Allen	T
, O	sate be executed obysician and the burial-transit	Examine	resulting in death) Last Due to (or as a consequence of):		10000	7/2-/
8760,	icate by physic s the bu	dica	d. MALNUTRIT	en & Bong	16145/1	
O. Box 6	attending for use as	Physician/Medical		Ectopic pregnancy		23d. Date of delivery Month Day Year
s, P.O	es that the de igned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 ☑ 10 3 ☐ Probably 4 ☐ Unknown
ord	w requir been si should	eted	CHRONIC KIDNEY D	1801556	24a. Was an	24b. Were autopsy findings available
Records,	sicien: The law certificate has b irector, page 2 s	Completed	UNDSEPSIS		autopsy performe	prior to completion of cause of
of Vital	Physicien: this certificantal director,	Be	25. Was case referred to medical examiner?	Other	h (Check only one	A CONTRACTOR OF THE PARTY OF TH
of	Physic r this c eral dir	. To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	ome 5 Residen 28d. Describe how	ce 6 □Other (Specify) vinjury occurred
ion	Attending F r death. ector: After by the funera	atior	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deatled the control of the deats of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of cariffier	29c. License number	29	d. Date signed (Month, Day, Year)
)	X		CARLO N-PRTALINGTING S	nmo DISYT	6 7	PRIE 16-2007
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,		21225	-
	Sta	ate	31. Date filed (Month, Day, Year) APR 1 9 2007 32. Registrar's Signature	Coarles		
	Regist		APK I 9 ZUU	7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 12:38 PM **Physician** 04 2007 FRANCIS J. BUSH 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL GOOD SAMARITAN N/A Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 K M 2 □ F 2/16/1920 PENNSYLVANIA 187-12-1143 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Maryland 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No BALTIMORE CITY N/A Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be n 21206 USA 3708 WOODLEA AVENUE Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1X1 Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) PT O'MALLEY LUMBER CO. College (1-4or 5+) Elementary/Secondary (0-12) PURCHASING AGENT 4 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JULIA BUCZKO UNAVAILABLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3708 WOODLEA AVENUE BALTIMORE, MD 21206 DOROTHY BUSH/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 ☐Removal from State MXBurial 2 ☐ Cremation 4/20/2007 PARKVILLE, MD GARDENS OF FAITH CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee all TOWSON, MD 21286 8521 LOCH RAVEN BLVD. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner AKDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trar Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv certificate has page 2 performed? Yes 2 No death? 1 ☐ Yes 2010 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hipatient 3□ DOA 2 NO 2 ER/Outpatient 1 ☐ Yes 2 this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury After t Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04,16,2007 16FR61

Maryland 21215-0036

Baltimore,

Box 68760,

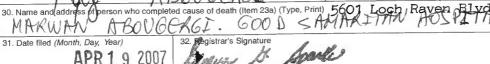
o

σ.

Records,

Division or Vital

State Registrar 31. Date filed (Month, Day, Year) APR 1 9



2007

21239

			1 - For State Registrer	State of Mary	land / Dep	artme		ealth and M	-		_	12537
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anna Julia Burg	er				1.	2. Date of D. April	eath Day	2007	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s	treet and number)	spital	4b. Cit	y, Town, or	Location of Death			County of Death	More.
	Funeral Director		5. Social Security Number 6, Sex	7. Age (II	yrs. last birthday,	If Und Months	er 1 Year S Days	If Under 24 Hrs. Hours Min.	8. Date of Bi		9. Birtl	hplace (State or Foreign unity) 'y land
	yland		Usual Residence of Decedent 10a. State 10b. County MD Paltimore		oc. City, Town or L Middle Ri							10d. Inside City Limits
	r 28e-f s	irector	MD Baltimor 10e. Street and Number	e I	Tiddle Ki		ip Code			10g. Citiz	zen of What Co	1 ☐ Yes 2 🕅 No untry?
	ath witi	raiD	113 Hughes Shore				1220				USA	
JN/A 036	be filed within 72 hours after death with the Maryland ital hygiene. A other than "natural", or Items 23a or 28e-f show event, it a Madical Examination must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	 12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 			edent of His ecry Cubar 2 No	spanic Origin? (S) n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		4. Race - Ame Black, White Specify: Wh	ncan Indian, e, etc. nite
A 1215-0	ne ne	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Us kind of w DO NOT		tion uring most of wor.	king		nd of Business/ eral Go	_{Industry} vernment
Reh ANN aryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other than eumatic event, Italia	To Be Co	17. Father's Name (First, Middle, Last) Rock Scola					18. Mother's Nam Mary D'			Sumame)	
Man	ges 1 and 2 should it of Health and Mer If item 27 le marks or other treumatic		19a. Informant's Name/Relationship (Ty) Mr. Clayton L. Burger			_		ore Rd.			r Town, State, 2 er, MD	
3W/more	Pages 1 and 2 nent of Health int: If item 27 I ury or other tre		20a. Method of Disposition 1 🖔 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Place of Dispondering Commetery, creed Holy Red	matory or	ame of other place Cem	4/21	Date /2007		cation - City or timore,	
Baltime	permit. Pages Department of I Important: If its any injury or or		21. Signature of Funeral Service License	Kimberly Dav				s of Facility Ruck, I			arford ore, MD	
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to time culate cause. Enter Underlying Cause (Disease or injury	cations that caused the cause on each line. Due to (or as a co	Canconsequence of):	ter the me	ode of dying), such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
~ 58760, ~	or Attending Physicien: The law requires that the death certificate be executed titler death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Cause, Cinear Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
.O. Box 68	that the death certificate ed by the attending phys detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic ⊒ Other (pregnancy (specify)			2	23d. Date of del Month	ivery Day Year
rds, P	quires that n signed b uld be deta	d by Pl	Part II. Other significant conditions cor	tributing to death but n	ot resulting in the I	underlying	cause give	n in Part I.		tobacco u		the cause of death?
Division of Vital Records, P.O.	The law requires that has been signe page 2 should be o	Completed							24a. Wa auto peri 1 Yes	s an opsy formed? 200 No	prior to death?	itopsy findings available completion of cause of
ital	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Dea			12.103	20110
of v	Physic this co	2	1 ☐ Yes 2 No		2 ER/Outpatie		1	4 [] (40) 311 g 11			Other (Spe	cify)
sion	tending fleath. Lor: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dale of Injury (Month, Day Ye		М		at ? ′es 2 □ No	28d. Describe			
Divi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certif	4 Homicide determined	28e. Place of Injury building, etc. (\$	Specify)				City or To	own, State))	iral Route Number,
	the Hosp nin 24 hor the Fune apletely fi	fedical	(Check only 2 Medical Exemit one)	sicien: To the best of mer: On the basis of ex- and manner stated	amination and/or in	rvestigation	on, in my op	inion, death occu		, date and	place, and due	to the cause(s)
	To To Coff	Σ	29b. Signature and title of certifier				9c. License		< 11	\wedge	e signed (Monti	
	20		30. Name and address of person who co			Print)		\$63 Ø	21237	י , ייר	11 17,	<i>100</i> 4
9	Sta Regist		Majid Cina, MD, 9 31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Accel .	er and a	e, MI)	ムハレンヤ			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 16 200° 4c. County of Death 300 M **Physician** Berg APRIL Elaine /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 405PITAL AGNES 8. Date of Birth (Month, Day, Yea May 24, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Social Security Number Days Hours Min. **Funeral** 1 □ M 2 🗓 F IL 75 533-36-7074 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a State 10h County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Glen Burnie Director Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21060 1201 Guilford Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No White Specify Specify: Baltimore, Maryland 21215-0036 þ 3K Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ruth Foreman Morris Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2316 Belvue Road Waynesboro, Mr. Scott Berg /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 19. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Stevensville,MD Chesapeake Cremation 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final doic Physiclan myllardia disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed end Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 month's? 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Donknown 1 🗌 Yes 2∐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No 24a. Was an autopsy performed? has 1☐ ¥es 2 □ No this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completely filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27 Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Barcono

Registrar

State

nelissa

31. Date filed (Month, Day,

Healtheave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** April 12, 11:38 PMM Allen Bias /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, May 30, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2 □ F 1940 66 Director 220-36-3188 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Director Prince George's Mt. Rainer the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 3353 Forest Drive #103 20712 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after nand Mental Hygiene.
Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isaac Bias Daisy Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once. 5999 Emerson Street Bladensburg, MD Mamie Bias/spouse 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3. Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Ronal Stensee Wader Director Wader Director ^{22. Name and Address of Facility} State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate ause (Final disease or condition resulting in double) **Physician** ACUTE CODONARY 3 MODOWE /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any facility to line of all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an STABETES MALLIATUS certificate has autopsy 1□ Yes 2☑No the Hospital or Attending Physician: 'in 24 hours after death.

the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D50689 SOUTHERN HIMTAL 7503 SURRATTA RO CLINIVAMD 20735 CNA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 15, 5:55A WILLIAM JOSEPH BARNES JR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 3, 1923 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** XXM 2 F 83 Maryland 219-16-4467 Director Usual Residence of Oecedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 📆 💥 Funeral Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 East Padonia Road 21093 USA Was Decedent Ever in U.S. Armed Forces? *XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural", or items 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XIX No Specify þ 3XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Route Owner Newspaper 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Barnes Sr Beulah Elizabeth Ludloff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun once. Daria A Barnes DTR 102 East Padonia Road Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gardens: 4/18/07 Timonium Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Sa 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1□ Yes 275 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Floright HOSTICE ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Became agriculed and fell at home 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 3 ☐ Suicide 09/2007 6 Could not be determined ace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Deugliters Home 192 G PADONIA ROLLUTROCHUE MO within 24 hours al

To the Funeral E

completely filled i Certifying Physician: To the sist of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minner as stated. g 2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sigrature and title of certifier and address of per on ho completed cause of death (Item 23a) (Type, Print) 6301 N Charles St, Baltmore, MD 21212

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

April 15,200

BARNES, William

32 Registrar's Signature

The law requires that the death certificate be executed Box 68760. P.O. Records, or Vital this Division

Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month PM BERNICE AMPA CALDWELL 1750 15 2007 APR 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Columbia Howard County General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 0, 5. Social Security Number 285–12–2010 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 OH 6. Sex Y 1921 1 □ M 2 🗙 F 86 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Columbia Howard ty Yes 2 No Funeral Director 10g. Citizen of What Country? USA 10e. Street and Number 6438 Dry Barley Lane 10f. Zip Code 21045 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify: White Completed by 3℃Vidowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Frieda Stuebe 17. Father's Name (*First, Middl*e, *Last)* **John Widowski** Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6438 Dry Barley Lane, Columbia, MD 21045 19a. Informant's Name/Relationship (Type. Print) Willard E. Caldwell Jr. / Son Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Sunset Memorial Park April 20,2007 North Olmsted, OH 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility}
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee . Morskall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK 5 DATS **Physician** /Medical Due to (or as a consequence of) Examiner PNEUMONIA 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be c Completed by No 3 Probably 4 Unknown STAGE RENAL DISEASE 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy perform 2X No 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Mnpatient 1 ☐ Yes 2 **N**0 2 ☐ ER/Outpatient 3 □ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: neral Director: After filled in by the funera Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and APR 15, 2007 D00163147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 5755 CEDAR LANE CCLUMBIA HOWARD COUNTY GENERAL HOSPITAL Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

APR 19

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) CHRISTIAN Physician ELOISE 5.40 P M APRIL 12,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Rock Glen Nursing & Rehab Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 137 F Yrs. 1920 Alabama Director 422-30-0298 86 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County in then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland N/A Baltimore Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21223 2706 Edmondson Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. I other then "i Elementary/Secondary (0-12) College (1-4or 5+) Switch Board Operator Phone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 27 is marked off Sanders Charles Ethe1 Peterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Turner (Grandson) 2706 Edmondson Ave., Baltimore, MD 21223 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. 4/20/07 Garrison Forest, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Fuenral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER METASTATIC Physician YEARS /Medical Due to (or as a consequence of): LIVER CERERAL AND BONE METASTASIS Examiner LUNG TIPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atten for u in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPER TENSION 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 1 Yes 2 ₺ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident lilled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Dire 0 the Hospitel 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0018362 anal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Ave. Suite 1210, Balto, Md21229 Komal K-Dang
31. Date filed (Month, Day, Year) M.D. 32. Registrar's Signature State 9 Registrar

amend 25 770 29 Print in Black indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month LASHAY CLAGGETT **Physician** 2001 6 /Medical 4c. County of Death
PRINCE GEORGES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUNTON MD 20735 PK

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Heyrs Min (Month, Day, Year) HOSPITAL CLINTON 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Director none Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examiner must be approximated or other traumatic event, Ite Marical Examiner must be approximated or other traumatic event, Ite Marical Examiner must be approximated or other traumatic event, Ite Marical Examiner must be approximated or other traumatic event, Items and other traumatic event, Items are also event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ▼ No Director Oxon Hill MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 #301 5122 Deal Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 II No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 ρ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marquetta S. Claggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7503 Surratts Road Clinton, MD 20735 SOuthern MD Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signature of Fun Theory ica Livensee Rona Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the injector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes X ☐ No or Attending Physician: 26. Place of Death (Check only one) : After this certific tuneral director, 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: / completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year) APR 1 9

VERGARA 1503 SURRATTS RD CLINTON MD 20735 32 Registrar's Signature 2007

completed cause of death (Item 23a) (Type, Print)

1)34302

George Christop		Conrad State of Maryland / Department of Health and I - For State Certificate of Death				7 1254
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Last)		Reg. N Date of Death Month Da	y Year	3. Time of Death 0412 hrs
		George Christopher Conrad 4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview 4b. City, Town, or Loc Baltmore		April 12, 2007	4c. County of Deatl	
Funeral Director	- 1	256-49-3036 1X M 2 F 39 Yrs. Months Days		8. Date of Birth(M 11/09/19	Foreig	thplace (State or gn puntry) Georgia
with the Maryland is 23a or 28a-f show any e.notifited at once.	Director	Usual Residence of Decedent 10a. State	ю	10g. (Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f shr ent, the Medical Examiner must be notified at once	Funeral	13 Township Road 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 2 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No	anic Origin? (Speci Mexican, Puerto Ric		White, etc.	States ican Indian, Black,
0036 within 72 hours aft iene. eer than "natural" Medical Examine	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Longshoreman	n (Give kind of work OO NOT use retired		b. Kind of Business/	Industry
	Be Com	17. Father's Name (First, Middle, Last) George D. Conrad He	3.Mother's Name (Fi	era Andr	en Surname)	
more, MD 21 Pages I and 2 should tent of Health and Me ant: If item 27 is ma or other traumatic ev	To	19a Informant's Name/Relationship (Type, Print) Helen Conrad, Mother 20a. Method of Disposition 19b. Mailing Address (Street and Park Indian Street and Park	Drive, La	as Vegas		7-0170
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		1 XBurial 2 Cremation 3 Removal from State 4 Donation, 5 Other Specify: 21 Signature of Fungral Service-Licensee M01113 22. Name and Address of		6/2007 C	edar Grov	e, Georgia J. Avery
Physician		Bryan Chape 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, surfailure. List only one cause on each line.	el, 215 Le	ee Ave.,	Chichama	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Heroin and alcohol intoxication Due to (or as a consequence of):			-	Death
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
760, ficate be executed g physician and the burial - transit	Medical	IF FEMALE: d. AMENDED AMENDED 4.23a, 27, 28a-f, perME, g866, 4/21/07 23c. If yes, outcome of pregnancy	TT		23d. Date of deliver	y
Box 687(e death certifice the attending pl	Physician/Medical	23h Was decadest program in the	Ectopic pregnancy	I .		Day Year
ords, P.O. E w requires that the d is been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		No 3 Pro	the cause of death? bably 4 Unknown utopsy findings available
Vital Record ysician: The law re this certificate has be director, page 2 sho	Completed	25. Was case referred to medical 26.Place of	of Death (Check onl	autopsy performed 1 V Yes 2	prior to	completion of cause of
n of Vital ding Physician a. After this cert funeral directe	: To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Ott	Other Nursing F		sidence 6 Othe	r.
IVISIO	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) residence	ilding, etc. 28	or Town, State)	ural Route Number, City altimore. MD
To the Hospital within 24 hours To the Funeral	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deand manner stated	death occurred at th	he time, date and	place, and due to t	ne cause(s)
	Z	29b. Signature and title of certifier 29c. License n O.C.M. 30. Name and address of person who completed cause of death (Item 23a)			ed. Date signed (Mo	onun, ∪ay, Year)
	tate	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Ba 31. Date filed (Month, Day, Year) 32. Rastrar's Signature	Baltimore, MD 2	21201		
Renis	rar	THILL TO A HILL BEST AND A SECOND B				

ORIGINAL

			F 100						nd Mental Hy		
			1 - For State Registrar		•		rtificate of			Reg. No.	14 12343
	Dhysiai	20	1. Decedent's Name (First, Middle	9, Last)					2. Date of De Month	nath Day	3. Time of Death
	Physicia /Medic		William	A -	Deh	h			April	16 2	007 05 AM
	Examin	er	4a. Facility Name (If not institution				4b. City, Town,			4c. County	1 -
			CHESTER KIVER H		TER '. Age (In yrs. Ia	et hirthday		If Under 24		Quet	9. Birthplace (State or Foreign
	Funeral Director		213.28.8231	6. Sex 7	. Age (in yis. ia	Yrs.	Months Days		Min. 8. Date of Bir (Month, Da		Country)
			Usual Residence of Decedent								111/21/09
	rylan	_	10a. State 10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	cto	MD. QUE	EN ANNE	Chi	ESTE	RIDWN				1 ☐ Yes 2 🔄 No
	death with the Maryland me 23a or 28a-f show Froust be petitied at	Funeral Director	10e. Street and Number	~			10f. Zip Code			10g. Citizen of V	•
	s 23e	erai	JOO MORGNEC 11. Marital Status	12 Was Dage	dent Ever in U.S	13		Hispanic Origin	n? (Specify Yes or No	U.5	e - American Indian,
	iter d	Fun	1 □ Never Married 2 ☐ Mar	Armed Ford	ces?	. 13.		·	n? (Specify Yes or No Puerto Rican, etc.)	Blac	k, White, etc.
8	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1□Yes 2₩No	Specify:		Specify	WHITE
21215-0036	within 72 hours after ene. than "natural", or ita na Modical Examina	Completed	15. Deceder	it's Education st grade completed)		(Give	dent's Usual Occu	during most o	of working	16b. Kind of Bu	usiness/Industry
2	within ene. than "	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use getire	90)		77.	
	filed w Hygiel other tl		3 17. Father's Name (First, Middle,	(act)		IKU	ckdriv	T	s Name (First, Middle		KING
and	d be f antal h ed of	Be C	MOCOTIN	74.				LilliA	. 1 1		
Maryland	2 should and Mer is marke sumatic	To	19a. Informant's Name/Relations	thip (Type, Print)		19b. Maili	ng Address (Stree		or Pural Route Numb		State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. The Modical Examiliar must be notified at once.		BRENTA L'SE ako	Davakte	≤R.	43 A	200KFE	LD AD	PASADEN	MMD. Z	21122
Baltimore,	of Hei		20a. Method of Disposition	f □ Paramalánar S		ace of Disponentery, cre	osition (Name of matory or other pla	ace)•	Date	0c. Location -	City or Town, State
Ē	it. Pages rtment of ortant: If it njury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		THAN BISIN	omy G	FISPE	RUSTRY 4	1-17-07	HOWEVE	R, MD.
alt	permit. Departr Importa any nj		21. Signatur o Fundal Service	icensee /		2	2. Name and Ad		eral Home And Cre	mation Center	DΛ
<u>.</u>	205 20		AN	Shu			260	Mountain F	Road - Pasadena	MD 21122	
			23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause on ea	ch line.				ardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		iratio	-	nd u mo	mia			6 days
	Examiner		,	Due to (c	or as a consequ	ence of):	Dale	*3			>Zueave
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a conseque	enes of):	PUS	9			11-12
¥	uted d ansit	Examiner	Sequentially list conditions, if any, leading to influedate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.							
0	ie be executed /sician and e burial-transit		resulting in death) Last	Due to (c	or as a consequ	ence of):			-		
3760,		licat		d							
x 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	220 H van outs	ome of present	1014					
Box	ath c attend for us	lan	23b. Was decedent pregnant in the past 12 months?		nth 2 ∐ Fetal ant at time of de	death 3[□Ectopic pregnand □ Other (specify)	су		23d. Dal Mo	le of delivery inth Day Year
P.O.	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		atii 01	_ Other (specify)				
	res that igned by be deta	y Pt	Part II. Other significant conditi						23e. Did	tobacco use cont	ribute to the cause of death?
Vital Records,	quires n sign	q pe	Demontiail	OPD; Cho	tructi	ve Si	wp Ap	nua	192	Yes 2□No	3 Probably 4 Unknown
000	aw requires s been si 2 should l	plet	HTNY BPH	7 Arth	ritis				24a. Was	s an 24b. \	Were autopsy findings available prior to completion of cause of
æ	sician: The law s certificate has b lirector, page 2 s	mo							perfe	ormed?	death?
ita	striffica ctor, I	BeC	25. Was case referred to medica examiner?					26. Place o	of Death (Check only		
of V	Physician: r this certific ral director,	그	1 ☐ Yes 2 No		patient 2 E		nt 3 DOA	w w	sing Home 5 Res		
n o	ding Physician: The I h, After this certificate ha funeral director, page	lon:	27. Manner of Death 1 Natural 5 ☐ Pendi	ig .	f Injury n, Day Year)	28b. Time o Injury	W	ork?		how injury occurr	red
isio	ttsndii death. ctor: A y the fu	cat	3 ☐ Suicide 6 ☐ Could	not be 200 Place	of Injuny - At hor	ne farm et	M 1 []Yes 2□No		(Street and Numb	per or Rural Route Number,
Division	for Attane after deatl Diractor:	Certification:	4 Homicide determ	nined buildin	g, etc. (Specify))	reet, lactory, office	,		wn, State)	
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifyi	ng Physician: To the I	best of my know	vledge, dea	th occurred at the	time, date and	place, and due to the	cause(s) and ma	anner as stated.
	n 24 t n 24 t ns Fu sletely	edical	(Check only 2 Medical one)	Examiner: On the ba	sis of examinati	on and/or in	rvestigation, in my	opinion, death	occurred at the time,	, date and place,	and due to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifie	$^{\prime\prime}$			29c. Licer	nse number		29d. Date signed	d (Month, Day, Year)
)			1 Parties	solder			De	5099	16	4/16	107
	3		30. Name and address of person	who completed cause	of death (Item	23а) (Туре	, Print)		~/	1 - at-	
			31. Date filed (Month, Day, Year	West M	istrar's Signat	100	المراز الم	us J	st. CC	25 Pertu	n 100 21620
	Sta Registr		APR 1	9 2007	Rome	b. 1	best				d (Month, Day, Year)
			131 11 4	U LUUI / J	J. T. J. J.		1 - N. W. C. C. T. C. C.				

DHMH 17 Rev 1/2001

Gregory Doppke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 | 2546

KUNK		1- For State	of Maryland / Depa	artment of rtificate of i		пап пууг	Reg.	No	
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Las		1			Date of Death	lav Year	3. Time of Death 1023 hrs
dical Exami	ner	Gregory 4a. Facility Name (if not institution, giv	D. Dopp		o. City, Town, or Location		pril 4, 2007	4c. County of Deat	
		Ocean Gateway & Buck B			Trappe			Talbot	
Funeral		5. Social Security Number 6. So	(2)		If Under 1 Year If Und Months Days Hour		,	MM/DD/YYYY) 9. Bi Forei	an l
Director		133-34-4617 123 Usual Residence of Decedent	M 2 F 62	Yrs.			03/01	/1945 N	ew York
any	İ	10a. State 10b. County	·	, Town or Locatio					10d. Inside City Limits
land f show	ē	CT. Fairfi	eld (Greenwi			1400	. Citizen of What Cou	1 X Yes 2 No
ne Mary or 28a	Director	10e. Street and Number 46 Stonehedge	Drive, So.		10f. Zip Code 06830		109.	USA	iniu y :
n with the ms 23a be not		11. Marital Status	12. Was Decedent Ever in U		Decedent of Hispanic Or s, specify Cuban, Mexica			14. Race - Ame White, etc.	ican Indian, Black,
er death , or ite	Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No or Dates: 1962—				,,	Specify:	hite
ours afte	d by	15. Decedent's Education (Specify o	or Dates: 1962— inly highest grade completed)	16a. Decedent'	s Usual Occupation (Give st of working life. DO NO	e kind of work		6b. Kind of Business	(Industry
nore, MD 21215-0036 ses I and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		rincipal	T use retired)		Heating	& Air Co.
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than umatic event, the Medica	mo	17. Father's Name (First, Middle, Last	:)	I		er's Name (Fi	rst, Middle, Ma	iden Surname)	
1215 De file ental H urked o	å	Allen Paul Do			Le	ena L	atella	l State State	- C:-C()2-42) O
MD 21215-003 d 2 should be filed withinth and Mental Hygiene, n 27 is marked other it	2	19a. Informant's Name/Relationship (Mary Doppke/Wi	*, , ,	1	Address (Street and Nu				
e, M l and 2 Health litem 2		20a. Method of Disposition 1 K Burial 2 Cremation 3	20b.	Place of Disposit	tonehedge tion (Name of cemetery, er place)	D	ate	20c. Location - City o	r Town, State
Pages nent of ant: If		4 Dopation 5 Other Specify	,: S	t.Mary	's Cemeter				
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Funeral Sarvice Lice	nsee	PH S	ame and Address of Facil	ALDI	FUNER.	AL SERVI	CE, P.A.
Physician		23a. Part I. Enter the disease, or com failure. List only one cause on e		h. Do not enter th	e mode of dying, such as	cardiac or re	spiratory arres	t, shock, or heart	ng Md20910 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a	Multiple Injuries						Death
e .		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of	of): 					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):					
ed	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):			-		
60, tre be executed hysician and e burial - transit	dical	UNPENDED IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions	AMENDED						
760, ficate be g physicist the burn	/Me	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of pre		al death 3 Ecto	pic pregnancy	<u> </u>	23d. Date of delive Month	ry Day Year
Box 6876: death certificate the attending phyed for use as the land	siciai	past 12 months?	4 Pregnant at time of d	do oth	ner (Specify)				
b. Bc the dea by the a	Phys	Part II. Other significant conditions	9 Olkilowii	resulting in the u	nderlying cause given in	Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ords, P.O. B w requires that the de s been signed by the should be detached	Ð						1 Yes		obably 4 Unknown
ords.	Completed						24a. Was ar autops	y prior to	autopsy findings available completion of cause of
Recol The law cate has	mo						perform 1 Yes 2		
ician: s certifi rector,	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Dea			tesidence 6 🗸 Oth	er: Scene
of V ng Phys ofter thi	1:12	1 Ves 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Ir	njury 28c. Injury at Wo	lPi	d. Describe ho	ow injury occurred n plane crash	
ion ttendir death stor: A the fu	ation	1 Natural 5 Pending 2 ✓ Accident Investiga	Apr 4, 2007	FOUND: 1023 hrs	1 Yes 2	No	•		Rural Route Number, City
Division of Vital Records, tall or Attending Physician: The law requires and tarted early After this certificate has been sill birector, page 2 should be led in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no determin	ot be	nome, farm, stree	et, factory, office building,		or Town Sta		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physi (Check only	ician: To the best of my knowle	edge, death occur	red at the time, date and	place and du	e to the cause	(s) and manner as st	ated.
To th withir To th compl	Medical	one) 2 Medical Examin 29b. Signature and title of certifier	and manner stated.	- Interest in the strip de	29c. License numb			29d. Date signed (A	
	-	Talay 18	71	•	O.C.M.E.			April 5, 2007	
10	1	30. Name and address of person who			n Street, Baltimore	MD 2120	11		
1	tate		sistant Medical Examine 32. Registrar's Signa	ature —		5, IVIL Z IZC			
Regis		71 6/ 6/ / 11	2007 Bleeze	N. Aca	ويجامه				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-02927 State of Maryland / Department of Health and Mental Hygiene Randal E. Dinsmore 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 16, 2007 1802 hrs Medical Examiner Randal E. Dinsmore 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Ellicott City 3229 Sonia Trail 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Maryland Months Davs Hours Director June 17, 1958 217-62-0421 XX M 2 48 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2XX No Ellicott City Howard or items 23a or 28a-f shovmust be notified at once. Limore, MD 21215-0036

. Pages 1 and 2 should be filed within 72 hours after death with the Maryland imment of Head and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 U.S.A. 3229 Sonia Trai1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' XX Never Married 2 Married 2**X X** No Yes Specify: White Yes XX No specify: If Yes, Give Year 3 Widowed Divorced Ś 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Restaurant Co-Owner 12 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Louise Dawson Harry Evan Dinsmore å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mother Patricia L. Dinsmore 203 Sunny King Dr.; Reisterstown, MD 21136 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Reisterstown U.M. 1XXBurial 2 Cremation 3 Removal from State 4/20/07 Reisterstown, MD permit. Pages
Department of
Important: I Church Cemetery Donation 5 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licen 11605 Reisterstown Rd. Owings Mills,MD2111 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ₫ leted Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy Compli has performed? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26 Place of Death (Check only one) ing Physician: 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 Other: Scene DΩA ER/Outpatient 3 Inpatient 2 this 1 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Victim of house fire Certification FOUND: Yes 2 ✔ No Division Natural Pending Director: hours after death. Apr 16, 2007 1400 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 3229 Sonia Trail, Ellicott City, MD Suicide (Specify) Single Family To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 Wedical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number April 17, 2007 O.C.M.E. h mo 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner State 31. Date filed (Month, Day, Year) gistrar's Signature

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

John Kendall Davis, Jr.

2	0	0	1		9	5	4.0	6
Lon	10	100	- 8	1	lane.	1	- 6	١

		1- For State Certifica	te of Death	Reg.	LUU. No.	1 1234
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Date	ay Year	3. Time of Death 0906 hrs
ai Laiiii	He	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	April 17, 200	4c. County of Death	09001115
		2590 Twin Landing Cove	Annapolis		Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hr Months Days Hours Min		MM/DD/YYYY) 9. Birth Foreign	
Director		218-14-4543 1XM 2F 82	Yrs.	Jan.28,	1925 Cour	^{htry)} Maryland
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		[1	10d. Inside City Limits
nd show a	ř	Maryland Anne Arundel Annap	olis			1 Yes 2 No
Maryland 28a-f show any d at once,	ectc	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
n with the Maryland ms 23a or 28a-f she be notified at once	ΙΟ	2590 Twin Landing Cove	21401		JSA	
ath wit fems 2	uneral Director	1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 		14. Race - America White, etc.	an Indian, Black,
fter de l'', or i	ഥ	3 Widowed 4 XDivorced or Pates: 1943–46	1 Yes 2 X No specify:		Specify: Whit	e
11215-0036 Metal be filted within 72 hours after death with the Maryland deals Hygiene Hygiene Harryland narked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. D	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use re		6b. Kind of Business/Inc	
21215-0036 uld be filed within 72 how Mental Hygiene. marked other than "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	•			
-00; d with giene ther the	Com	17. Father's Name (First, Middle, Last)	Self-Employed CF	'A le (First, Middle, Mai	Accounti	ng
215 be file ntal H. rked o	Be (John Kendall; Sr. John Kendall Davis,	Sr. From	ie Gray	,	
Baltimore, MD 21215-0036 Deamit Pages I and 2 should be filed within 7 Deamiter of the filed with a filed within 7 I mportant: If tiem 27 is marked other than injury or other traumatic event, the Medica	J.		Mailing Address (Street and Number or			
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic			816 Still Leaf Lane Disposition (Name of cemetery,		ct City, MD	
More Pages 1 nent of H ant: If it		1 X Burial 2 Cremation 3 Removal from State Crowns	ry or other place)		Crownsville	
Baltimo permit. Page Department or Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee)				
Dep Dep Imp		(Inhatell	22. Name and Address of Facility Ste Funeral Home of 1630 Edmondson A	Catoñsvil venue; Ca	le,Inc. itonsville,	MD 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.				Approximate Interval Between Onset and
Medical .xaminer		Immediate Cause (Final disease or condition resulting in death)	S			Death
		bac to (or as a consequence or).				
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
P ko i≅	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	 ,			
cecuted n and transit		d.				
760, Toste be executed Thysician and The burial - transi	Medical		-28a-f, perME, g867, 5/1	L5/07 TT		
6876 certifical nding ph	-	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month Da	y Year
Box 68 e death certifi the attending ed for use as t	Physician	4 Pregnant at time of death 5 1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
- e - e	Ph.	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
S, P.O.	ed by			1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
ord: tw requas been	plet			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
Rec The Iz icate h	Completed			performe 1 Y Yes 2	ed? death? No 1 ✓ Yes	2 No
Division of Vital Records, rat or Attending Physician: The law required in Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 4 Innation 2 ER/Qu	26.Place of Death (Check tpatient 3 DOA Other Nurs			
of V g Phys ter thi	: To	27. Manner of Death 28a Date of Injury 28b. T	tpatient 3 DOA Other Nurs ime of Injury 28c. Injury at Work?	ing Home 5 Re 28d. Describe how	w injury occurred	Scene
on cending sath.	tion	1 Natural 5 Pending FNd 4/17/2007 FNd	8:50 am 1 Yes 2 X No	subject f	ell	
ivisi I or Att after de Direct	Certification:	A Accident investigation	m, street, factory, office building, etc.	28f. Location (Stre	eet and Number or Rura	al Route Number, City
Di sspital hours a neral / filled		4 Homicide determined (Specify) residence		590 Twin I	anding Cove,	Annapolis, MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The the To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal one) 2 ✓ Medical Examiner: On the basis of examination and/or in				
T wii	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Moni	th, Day, Year)
		Theodore M. The ex in was	O.C.M.E.	/	April 18, 2007	
0		30. Name and address of person who completed cause of death (Item 23a)	nor 111 Ponn Street Dellin	ro MD 24204		
2	tate	Theodore M. King, Jr., MD. Assistant Medical Exami 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ner 111 Penn Street, Baltimo	1e, MD 21201		
Regis			frest.			
DHMH 17 Rev 1/2	001	ORI	GINAL			

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

BOON POH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

7601

32. Registrar's Signature

Marchall and

LIM

29c. License number

D37254

OSLER DRIVE TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

State of Maryland / Department of Health and Mental Hygierre

1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician APR 12 2007 6:15 P M JAMES EUGENE FALTYNSKI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs Jan 28, 1924 Wisconsin Director 396-38-0052 83 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. Count 10c. City. Town or Location ir than "natural", or Items 23a or 28a-f show The Medicul Examinar must be notified at 1 XYes 2 No Director MD Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 923 Montrose Avenue 20707 death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No It Yes. Give Year or Dates: 1943-63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Marine Corps 12 Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Faltynski, Sr. Helen Kubiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 Montrose Ave. Laurel, Maryland 20707 Donald B. Faltynski /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Coremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Arundel Crematory Apr 18, 07 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer see 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner signed by the attending physician and J be detached for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2[] No 1 Yes 2X No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 🗌 Pendina 1 X Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident illed in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Surcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral L Fo the Hospital 29a. Certifier 🗽 ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0101238627 (VA) 04 13/2007 30. Name and address of person who compreled cause of de in titl m Zia) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LT BETHESDA MD 20889-5600 MICHAEL C. FLANAGAN MC USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9

within 24 hours a

To the Funeral I

completely filled

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

phalm

AARON J-CHARLES

APR 19

32 Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARCON J. CHAN LES NO 6701 N. Charles St Trusson no 2(204

29c. License number

58303

29d. Date signed (Month, Day, Year)

APRIL 17 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Vear MARIE GARdner 7. 448 M 04 /Medical 17 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Morkyland Greneral
5. Social Security Number | 6. Sex Baltimore HOSpital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Auq, 14, 19 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 2 😿 F Days Hours 217-20-2041 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at Director Baltimore MD 1 DYes 2 □ No -28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Menial Hygiene. Important: If Item 27 is marke: other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 1150 21201 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY Brooks BAROKS Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Daughter Tonya Butler 20a. Met of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ✓ Bunal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-21-07 Zion 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael Ziglier Fun Svc, P.A. 3512 Frederick AVE, Balte 23a. Part1. Enter the disease, or cooplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY /Medical Due to (or as a consequence of): Examiner FND Sequentially list conditions, it are the day to fine plat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last STACE RENAL Examiner Dire to (or es a nonsequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 DUnknown Be Completed FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? After this certificate a 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of al or Attending P safter death. Il Director: After t d in by the funera Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland General Aspital ad havan 32. Regional's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

07-02798	
Lorny Tyrono	Criffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 7 1 2 5 5 3 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day April 13, 2007 0745 hrs Medical Examiner Larry Ivrone Griffin

4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 309 Key Avenue Brooklyn 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director Country' 1 X M 2 F 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County 1 Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code OUY+ Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Never Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify Specify: 13/ack 3 Widowed ≥ Pages 1 and 2 should be filed within 72 hours and of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Be inda M. Hood 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rin M. Griffin 2 Cashew Court Bel Air mo 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition timore, crematory or other place) Burial 2 Cremation 3 Removal from State ruid Thiolac 04.21.07 Other Specify Vayahn C. Greene Junera 21. Signature of Funeral Service Licenses Mandallstain Liberty Thoad 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d Date of delivery IE EEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 9. O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24a Was an 24b Were autopsy findings available has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one 25. Was case referred to medical Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes this 28a. Date of Injury FOUND: Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot FOUND: Natural Yes 2 ✔ No Pendina hours after death. by the Apr 13, 2007 0717 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 309 Key Avenue, Brooklyn, MD determined (Specify) Local Street 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 13, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/20b, perFH, G866, 4/19/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 16, 2007 ear **Physician** Richard T. Gunning 5:20 pm /Medical 4a. Facility Name (If not institution, give street and number)
Homewood At Crumland Farms 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick Examiner 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 05/30/1929 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MA Funeral 1**⊠**M 2□F 025-20-0484 77 Yrs Director Usual Residence of Decedent the Maryland 10b. County Frederick 10a. State 10c. City, Town or Location f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic svent. The M-cital Examiner must be notified at 10d. Inside City Limits MD Frederick 1 Yes 2000 Completed by Funeral Director 10e. Street and Number 7407 Willow Road 10g. Citizen of What Country? USA 10f, Zip Code 21702 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager I.B.M. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James A. Gunning Marion Corey 19a. Informant's Name/Relationship (Type, Print)
Audrey M. Gunning / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Sarakumitt Lane, Harwichport, MA 02646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 4/28/2007 May 5,2007 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Everett, MA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer lung **Physician** 41ar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vital To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Anursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ð 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031058 April 17, 2007 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10200 Coppermine Road, Woodsboro, MD 21798 Gene (F. Ashe M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2007

Tob: 5: 20p

SOM

Richard

Known to physician as

Goenle

32 Registrar's Signature

Registrar

State

8600 Snowden River Pkwy, Suite 301,

Columbia, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Pegistrar's Signature

STAGE S

M.D.

Harry Li,

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** PM TARGARET APRIL 2007 6 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER Baltimore County Randallstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 29, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🎖 F Yrs. Ireland 81 1925 Director 579-44-8553 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "netural", or Items 23s or 28s-f show treumstic event, the Medical Examples must be confided at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore County Pikesville 10g. Citizen of What Country? 10e. Street and Number 8320 Meadowsweet Road **USA** death v 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygene. Importent: If itam 27 is marked other than "ne eny injury or other freumatic event, tra Mading 2006. Cosmetic Elementary/Secondary (0-12) College (1-4or 5+) Electrologist Services yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Timothy 0'Sullivan Margaret Breen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward K. Gavin (Husband) 8320 Meadowsweet Road, Pikesville, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Ch Cem. 4/20/2007 Baltimore, Maryland 21. Signatury 1 Funer I S. 7 de Loursee Martin D. Lawson ²² Name and Addiess of Facility MITCHELL—WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MTRACEREBRAL HEM CRRHAGE /Medical Due to (or as a consequence of): Examiner Se ventially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 ☐ Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after d filled in by 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of celtifier hla, m.o D41410 G APRIL 16 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) JOGINDER CENTER RANDAUS TOWN MD MINTHWEST 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parker Registrar APR 19 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time-of Death Day PEGGY GOODHUES PRIL 17 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Brightwood Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1 Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 □ M XX F Months Days Hours Min. Maryland 214-12-0021 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes XX No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Belmullet Ct #201 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo XX Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Gehr Shriver Mildred Seibert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Shriver Goodhues 8 Belmullet Ct Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N□ Burial 2XX remation 3 □ Removal from State GreenMount Crematory 4/20/07 Baltimore, Maryland ☐Donation 5 ☐ Other (Specify) nature of Funeral Jervice Ligensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 . Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA MONUTES STAGE disease or condition resulting in death) Due to (or as a consequence of): THRIVE days FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed' 1□ Yes 2□No 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-1 show any InJury or other traumatic event, the Medical Examiner must be notified as

Baltimore, Maryland 21215-0036

Examine

the burial-transit physician as t aftending p as been signed by the a hast certificate Be P Certification:

Physician/Medical þ Completed

of the nospinal within 24 hours after death.

To the Funeral Director: After this of the Funeral Director after this of the Funeral director after the funer

Division or Vital Records, P.O. Box 68760,

Physician:

or Attending

To the Hospital

State Registrar

25.	Was case examiner?		to	medical	
	1 TYes	₩ No			

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

(Check only one)

27. Manner of Death 5 Pending investigation Natural 2 Accident 3 ☐ Suicide

6 Could not be determined 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO053150

APRIL 17 2007

5 hakun mala

UPTE 17. D. 9650 SANTIAGO ROAD COLUMBIA 32. Registrar's Signature

DHMH 17 Rev 1/2001

Medical

The section of	Phy /N Exa	/si led
Division or Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 34 hours offer death.	IIII 24 TOURS are upout. The Fineral Director: After this certificate has been signed by the attending physician and

		For State Registrar	State o	f Maryland	-	artment of H ertificate of I		d Mental Hy	giene Reg. No.	2007	12558		
		Decedent's Name (First, Midd	tle, Last)					2. Date of Do		Vens	3. Time of Death		
Physicia /Medic		James Paul	Heaps					APRI	Day	T Year	7 11:35 PM		
Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of D	eath	4c. (County of Death	1		
1.5		SINAL HOSPITA		TIMOR		Balti	more	Hrs. I o Data of Di		J 0 5: 11			
Funeral Director		5. Social Security Number 216-05-5941	6. Sex 1 M 2 ☐ F	7. Age (In yrs. la 87	ast <i>uirtna</i> ay Yrs.	Months Days		Ain. (Month, D	ay, Year)	Cot	nplace (State or Foreign untry)		
Jirector		Usual Residence of Decedent		0/				March	3, 19	20 Mary	Land		
how	_	10a. State 10b. Count	У	10c. City	, Town or L	ocation.					10d. Inside City Limits		
Ba-f s	Director		Arunde1	Gle	n Bur						1 ☐ Yes 2 ☑ No		
or 2 be no	Dire	10e. Street and Number	D A	- T)		10f. Zip Code				zen of What Coi	untry?		
is 23gmust	eral	101 N. Charter		edent Ever in U.S	3 13	21061 Was Decedent of H	isnanic Origin	7 (Specify Ves or N	US.	A 14. Race - Amer	ican Indian.		
Department of Health and Mental Hygiene innorment of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Ma 3 ሺ Widowed 4 □ Divorce	Armed Fo	orces? 2⊠No ve		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:		Black, White Specify: Wh	, etc.			
nature ical E	ted	15. Decede	nt's Education est grade completed)		16a. Dece	edent's Usual Occup e kind of work done	nd of Business/I	ndustry					
e. Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retired							
her #		12 17. Father's Name (First, Middle	2 (act)		Pol	ice Office	w Enfor	cement					
ed of	Be	Frank Heaps	s, Last)					Name <i>(First, Middle</i> na McClell		Surname)			
nd Me	ᅀ	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mail	ling Address (Street				Town, State, Z	ip Code)		
alth ar 27 is or trau		David P. Heap	s Sc	n	101	N. Charte	r Drive	Apt D: (Hen	Burnie.	MD 21061		
of He		20a. Method of Disposition	-		ace of Disp	oosition (Name of ematory or other place	;	Date		cation - City or			
ant: II		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other		Lor		Park Ceme							
Depart Import any inj once.		21. Signature of Juneral Service	e ensee	M0129	0	22. Name and Addre Funeral I 1630 Edmo	ss of Facility S Home of Ondson	terling A Catonsvi Avenue; (shton lle, Caton	n Schwa Inc. sville.	b Witzke MD 21228		
		23a. Part1. Enter the disease, shock, or heart failure. Li	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death										
ysician		Immediate Caus (Final disease or condition	SE	PSis							20 BAYS		
Medical caminer		resulting in death)	Due to	(or as a consequ	ence of):	0.10							
100	7	Sequentially list conditions,	b. Due to	(or as a consequ	lence of):	PHEUM.	INFE	CTION					
insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
n and ial-tra	Exa	resulting in death) Last Due to (or as a consequence of):											
physician and s the burial-transit	dical	g											
ng ph as th	Med	IF FEMALE:											
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									very Day Year		
ned b e deta	by Phy	Part II. Other significant condi	tions contributing to d	eath but not resu	Iting in the	underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?		
en sig		End stage He	ial disea	se on h	work	alypris		1	Yes 2]No 3∏Pro	obably 4 🕱 Unknown		
2 sho	plet	Chronic Res	piratory	Failure	2	U		24a. Was	an	24b. Were au	topsy findings available completion of cause of		
ate ha	Completed	Anemia	7					peri 1□ Yes	ormed?	death? 1 ☐ Yes	2 □ No		
ertific sctor,	Be (25. Was case referred to medic examiner?				la.		Death (Check only	one)				
this cal dire	ဥ	1 Yes 2 No		` -	ER/Outpatie		4 🗀 Nursii	ng Home 5 ☐ Res			cify)		
After funer	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	ing 28a. Date (Mortigation	oth, Day Year)	Injury	Wor	yaı k? Yes 2∐No	28d. Describe	now injury	y occurred			
death ctor: y the	ficat	3 Suicide 6 Could	not be 28e. Place	of injury - At ho	me, farm, s	treet, factory, office	100 2	28f. Location	Street and	d Number or Ru	ral Route Number,		
s after	Certification:	4 ☐ Homicide deter	build	ling, etc." (Specify	")			City or To	wn, State))			
n 24 hour. ne Funers sletely fills	Medical C		ring Physician: To the al Examiner: On the b and mar										
withi.	M	29b. Signature and title of certif	so M)		29c. Licens	e number 4621		29d. Date	e signed (Month	1, Day, Year)		
b		30. Name and address of person S: ZABC GABELT	n who completed cau	se of death (Item	23a) (Type	Print) LE AVE, SIN	Ani Hos	PITAL OF	BALT	1more/	1007 h0,21215		
Sta		31. Date filed (Month, Day, Yea	7007 32.1	Registrar's Signat	ture	A . 60 a							
Registr		ALK T ?	LUUI Lage	to be a find	100					 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Catherine Ann Holden 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL 13A LTIMORI N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Jul. 11, Director 44 1962 Maryland 220-90-6981 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items one contrainment. 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 □Yes 2 No Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5720 Richardson Mews Square 21227 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Accounting Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Blair Decker III Carolyn Joan Wrobel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn J. Decker - Mother 3233 Kessler Road, Lansdowne, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) 4-20-2007 Crematory Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS /Medical Due to (or as a consequence of): Examiner DAYS RENAL FAILURE Sequentially list conditions, if any, leading to him adjust cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DAYS KALEMIA PER Due to (or as a consequence of physician a Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Johnnown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 Division or 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10051865 APRIL 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSPITAL BALTIMURE IND 57 MARLES CURTIS 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1749 HELEN CATHERINE HARPER 11 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. las BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1 ☐ M 21X F Hours 220-20-6448 FEB. 15, 1930 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No BALTMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GENESIS FUTURECARE NORTHERN PARKWAY 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🛛 No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH HOUSEKEEPER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOTT BROWN LUCILLE GRESHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE FOWLKES/SISTER 1921 E. NORTH AVE., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8710 DOGWOOD RD. Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 04/24/2007 WINDSOR MILL, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the diseas or complications that shock, or heart failur. List only one cause on a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEPSIS DUE URINARY TRACT INFECTION Due to (or as a consequence of): PNEUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c If yes outcome of pregnancy

Physician /Medical Examiner

Examine

/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f shov must be notified at

Director

Funeral

þ

Completed

Be 2 MD

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

is marked other

Department of Health Important: If item 27 any injury or other tr once.

Pages 1

Baltimore, Maryland 21215-0036

physician and s the burial-tran

Division or Vital Records, P.O. Box 68760,

ıysıcıan	in the past 12 months? 1 Yes 22 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown	23d. Date of delivery Month Day Year
ed by Fr	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. RENAL DISEASE	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Complet	PERIPHERAL	VASCULAR DISEASE	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ນ	25. Was case referred to medical examiner?	26. Place	of Death (Check only one)
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nur	sing Home 5 ☐ Residence 6 ☐ Other (Specify)
allon.	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Ďate of Injury (Month, Ďay Year) 28b. Time of Injury Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe how injury occurred
Seruic	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
I Cal	29a. Certifier Certifying Pt (Check only one)	nysician: To the best of my knowledge, death occurred at the time, date and miner: On the basis of examination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner as stated. h occurred at the time, date and place, and due to the cause(s)

29c. License number

GUPTA, GOOD SAMARITAN HOSPITAL, BALTIMORE

29d. Date signed (Month, Day, Year)

MI

State

29b. Signature and title of dertifier

RENU

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Almeda Hepburn 7:20 PM Apri 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Burni Anne Arunde Caltimore Washington Medical Center Glen If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🖫 F 214-44-9695 Dec. 1944 Director 62 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Pasadena 1 ☐ Yes 2 X No Director Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 8837 Ft. Smallwood Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Hepburn, Vinginia Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 Custodian permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: if item 27 Is marked other any Injury or other traumatic event, til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lentz Whellan Romaine D. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Trappe Church Road, Darlington, MD 21034 ddaughter) Maleia Winter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 19 Metro Crematory Inc Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Stallings Funeral Home, PP.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10059190 APRIL 15 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAFFOR-BONNIE

1

State Registrar

GEGRAF

31. Date filed (Month, Day, Year)

APR 1 9 2007

DHMH 17 Rev 1/2001

32. Registrar's Signature

BATTMARE

LUASHINGTON MED

		For State Registrar	State of	Maryland	•	artment rtificate			and M		jiene	007	12562
Physicia /Medic Examina	in al -	1. Decedent's Name (First, Middle Victor 4a. Facility Name (If not institution The Story Stor	give street and numb	oer)	tib	4b. City, T	own, or		of Death	2. Date of Dea Month	Day 4c. Co	Year	3. Time of Death 10: 26 AM h
Funeral Director		5. Social Security Number 286-07-8969 Usual Residence of Decedent		Age (In yrs. las		If Under 1		If Under:	24 Hrs. Min.	8. Date of Birth Month, Day 12/16/)	9. Birth	hplace (State or Foreign untry) OH
e Maryland 8a-f ehow	Director	10a. State 10b. County	ahoga	10c. City,	Town or Lo		edfo	ord					10d. Inside City Limits 1. 1 Yes 2 □ No
a 23a or 2		10e. Street and Number 6065 Robert D			10.1	10f. Zip C	44	1146				n of What Co	
S. S	by Fur	11. Marital Status 1 □ Never Married 2 □ Marri 3X Widowed 4 □ Divorced	12. Was Deceded Armed Force ed 122 Yes 2 If Yes, Give Year or Date	es? □No TATLAT T.T		was Decede if Yes, specif		Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		. Race - Amer Black, White pecify: V	
within 72 ane.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4		16a, Deced (Give life, I	dent's Usual kind of work DO NOT use Cus	Occupa done di retired)	uring mosi)	t of worki	ng	16b. Kind of Business/Industry Real Estate		
# # # # # # # # # # # # # # # # # # #	To Be C	17. Father's Name (First, Middle, I Matthew Intiha	r					Ma.	ry :	(First, Middle, Popet			
Baltimore, Marylar perrit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic a		19a. Informant's Name/Relationsh Paul Intihar / 20a. Method of Disposition	nip (Type, Print) Son			of Address (Clay Csition (Name		Road		ppa, MD		own, State, 2	
Caltimor permit. Pages Department of Important: If it any njury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (So 21. Signature of Funeral Service I	pecify)	cem	ehave	natory or oth en Cem	eter	су Ар		20,2007 Funera	May	field	Village, OH
Certificate be executed with the principle of the princip	Exam	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequer as a consequer as a consequer	ythence of):						est,		Approximate Interval Between Onset and Death
death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Fetal de it at time of deat	eath 3	Ectopic pred					230	d. Date of deli Month	very Day Year
law requires that the as been signed by the should be detached.	þ	Part II. Other significant condition	ns contributing to deal	th but not resulting	ng in the ui	nderlying cau	use give	n in Part I.		23e. Did to			the cause of death?
The lay	Completed	Perisharal W Failure to 25. Was case referred to medical	Thrue	D'1500	20						med? 2DXNo	24b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of
ng Phy fter this	ertification: To Be	was case referred to inedical examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 4 Homicide determine Homicide Could in determine Could in deter	ation of be 28e. Place of		VOutpation Bb. Time of Injury a, farm, str	286 M	c. Injury Work	r: 4□Nu	rsing Hor	ne 5 ☐ Reside 28d. Describe he 28f. Location (S. City or Town	ence 6 [ow injury o	occurred	ral Route Number,
To the Hospital or Attendi	edicai Ce	29a. Certifier Certifying (Check only one) 2 Medicel E	g Physicien: To the be Examiner: On the basi and manne	is of examination	edge, death n and/or inv	n occurred at vestigation, in	the time	e, date and inion, deat	d place, a	and due to the c ed at the time, d	ause(s) ar ate and pl	nd manner as lace, and due	stated. to the cause(s)
To the vithin to the complex	Σ	29b. Signature and title of certifier			20) /7:			number	179			signed (Month	
Stat		30. Name and address of person viscous Security 31. Date filed (Month, Day, Year)	2 5505 32.4eq	Hall Construction of the state	aa) (Type,	JUICO	3 C	rele	DC1.	14-1026	-110	Max	7 91933
Registra		APR 1 9	2007	iva B	S	racks							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otato of Maryia		rtificate of			-	Reg. No	6001	12553		
	20	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	eath Da	v Year	3. Time of Death			
	/Medic	100	Elaine R. Ivi	April										
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Locatio	n of Death	_	40	. County of Death	1		
	. d.	S, 48	605 Edmondson			Catons	vill	.e			Balti			
	Funeral		Social Security Number 6. Se	□M 2√FF	s. last birthday, Yrs.	If Under 1 Year Months Days	Hours		Date of Bir (Month, Da		9. Birth	nplace (State or Foreign intry)		
	Director		218–12–3214 Usual Residence of Decedent	84	113.				Sept.	8, 1	922 Mar	yland		
	and		10a. State 10b. County	10c. C	City, Town or L	ocation						10d. Inside City Limits		
Appropri	Maryl f sho ed a	5	Maryland N/A							1⊠Yes 2 No				
	the 28a-	rect	Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What								tizen of What Cou	untry?		
	with sa or t be	Funeral Director	1306 Dellwood Av	renue		21211	l				USA	•		
	ns 2:	era	11. Marital Status	12. Was Decedent Ever in				Origin? (Spe	cify Yes or No	0-	14. Race - Amer			
(0	ifter or iter	표	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐No					Rican, etc.)		Black, White	, etc.		
ĕ	urs a al', o Exan	by	3 XWidowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 No	Speci	ty:			Specify: Wh	ite		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, <u>the Medical Examiner must be notified at</u>	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)			na	16b. k	Kind of Business/I	ndustry		
2	thin an "i	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)					Vining					
7	od wi	5	12		Homemaker 18. Mother's				Own Hon her's Name (First, Middle, Maiden Surname)					
Maryland	be file	Be	17. Father's Name (First, Middle, Last)					ther's Name						
<u>yla</u>	Men Men arke	၉	William Conoll						Anna	Carlin				
lar	2 sh and is m raum		19a. Informant's Name/Relationship (7							ute Number, City or Town, Sta				
	and lealth m 27		Bruce T. Ivins	Son		05 Edmond		Y						
ore	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	nemoval nom state		osition (Name of ematory or other pla	ice)	1	ate		ocation - City or			
Ξ.	Fa tant: jury		4 Donation 5 □ Other (Specify		A	of Faith			2007	Ful	lerton,	Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Juneral Service Licen	Se Huss) B	22. Name and Addr urgee-Her 631 Falls	ess of Fa	eitz 1	unera	l Ho	me, Inc.	21211		
			23a. Part1. Enter the disease, or comp	olications that caused the de	ath. Do not er	nter the mode of dy	ing, such	as cardiac o	r respiratory a	arrest,	arytano	Approximate Interval Between		
	Physician		Immediate Cause (Final											
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):											
	Examiner				,									
	- Za	Examiner	Sequentially list conditions, if any, course to the cause. Enter Underlying Cause (Disease or injury	b. Due to or as a conse	equence of):									
7.	uted		Cause (Disease or injury that initiated events	C										
Ó	exec an an rial-tr		resulting in death) Last	Due to (or as a conse	equence of):									
68760,	tificate be executed g physician and as the burial-transit	cal		.d	.d									
	rtificate be executed ng physician and as the burial-transit	Physician/Medical												
Box	th cer endir r use	N/ug	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg 1□Live birth 2□Fe			23d. Date of de							
	deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at time of		□Ectopic pregnand □ Other (specify) _					Month	Day Year		
P.O.	at the by the	h	9 🗆 Unknown											
	w requires that the death ce been signed by the attendi should be detached for use	by F	Part II. Other significant conditions c	ontributing to death but not re	esulting in the	underlying cause gi	ven in Pa	rt I.				the cause of death?		
ğ	equir en si ould I	eq	Diobetes						1 🗆	Yes 2	2 No 3 Pr	obably 4 ☑Unknown		
Division or Vital Records,	e law r has be je 2 sh	Completed	- Hyperten	5757					24a. Was		24b. Were au	topsy findings available completion of cause of		
Ě	The ate has bage	E	21						perf 1□ Yes	formed2	death?			
Ħ	ding Physician: The h. h. After this certificate ha funeral director, page	Be C	25. Was case referred to medical				26. PI	ace of Death	(Check only					
2	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2☑No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3□ DOA Ot	her: 4 🗆	Nursing Hor	ne 5 🗹 Res	sidence	6 □Other (Spec	cify)		
0 0	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	iry at ork?	2	28d. Describe	how inj	ury occurred			
<u>Ö</u>	endir ath. or: A	atic	2 Accident investigation				Yes 2	□No						
Ξ̈́	r Att	Certification:	3 Suicide 6 Could not be 4 Hornicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, s cify)	treet, factory, office		4	28f. Location City or To			ıral Route Number,		
	ital o rs aff rai D	Se												
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical		ysician: To the best of my k niner: On the basis of exami and manner stated.										
	ro the	Me	29b. Signature and title of certifier			29c. Licen	se numb	ər		29d. D	ate signed (Mont	h, Day, Year)		
\	->-0) C . ' N O!	no la		W	530	328		An	12,200	57		
			30. Name and address of person who	completed cause of death (It	em 23a) (Tvne			~0		ripi	10100	3/		
	U		Craig Gold De			eet Bal	t'uma :	e Mar	Ladu.	2121	١			
F	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	B		~, 1 'Vil	3121111	- 1 -	1			
	Regist		APR 1 9 2	007 Seguen	J. A.	ORALL B								

		-	For State Registrar	State of Maryland	•	nt of Health and N	, ,	iene ₂ 0 0 7	12564
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)	rles Jo	mson		2. Date of Deat	Day Year	3. Time of Death
j.	Examin Funeral Director	er	213 72 3121	al of Ball	mira Ba	er 1 Year if Under 24 Hrs.	8. Date of Birth (Month, Day, Dec 2	Year) Co	nplace (State or Foreign untry) Any land
	Maryland -fehow		Usual Residence of Decedent 10a. State 10b. County MA		Town or Location	-e			10d. Inside City Limits 1 ▼Yes 2 □ No
	death with the Maryland ims 23e or 28e-f ehow ir instal be politied at	Funeral Director	10e. Street and Number 3602 Mundu	womin Ave	>	1ip Code 21216		Og. Citizen of What Co	ł
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene the Health so thems 28e or 28e-1 show item 27 is marked other than "netural"; or items 28e or 28e-1 show other traumatic event, the Medical Exacting fraint to notified at	P	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		edent of Hispanic Origin? (Specify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0	d within 72 h giene. ar then "netu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life. DO NOT	vork done during most of wor	king	Labor	
Maryland	ould be filed Mental Hygi arked other atic event, I	To Be (17. Father's Name (First, Middle, Last) Charles Edu			Elono	ra Ro	Maiden Sumame) bvn 507	
Mar	nd 2 sho alth and 27 is mu ir treumu		19a. Informant's Name/Relationship (T) Sylvia Rome			ss (Street and Number or Ru			
Baltimore,	eges 1 an of of Heal t: if item? / or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	ace of Disposition (Numetery, crematory of	lame of r other place)	Date	20c. Location - City or	Town, State
Baltin	permit. Peges Department of important: If I any injury or		21. Signature of Funeral Service Licens		22 Name	and Address of Facility and A. Gran Fred Hulton			/
760,	Physician /Medical Examiner period and prical-Itausii period and per	cai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Matastad Due to (or as a consequ	nence of):	Cancar	or respiratory arr	rest.	Approximate Interval Between Onset and Death
P.O. Box 68	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic			23d. Date of de Month	livery Day Year
Division of Vital Records, P.	The law requires thet the site has been signed by the bage 2 should be detache	5	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	g cause given in Part I.			robably 4 🔲 Unknown
al Rec		Completed					autop perfor	sy prior to death?	utopsy findings available completion of cause of
Vita	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 280	ER/Outpatient 3	Other	ath (Check only o	ne) lence 6 □Other (Spe	ncify)
ion of	ng Ph fter th ineral	 	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		now injury occurred	
Divis	Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28f. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
	ne Hospital or 124 hours efte ne Funsral Dir lietely filled in	Medical	29a. Certifier 1 Certifying Phy 2 Medical Example one)	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wiedge, death occum tion and/or investigati	ed at the time, date and place ion, in my opinion, death occur	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple(×	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	
	6		30. Name and address of person who o	completed cause of death (Item	1 23a) (Type, Print)	BS931652 Imai Hospi	T 1	LB 07	, 200 7
2	St. Regist	ate rar	31. Date filed (Month PR 119 2	32. Rustrar's Signa	ture		Jac DI	DOUNT	~ (2

DHMH 17 Rev 1/2001

Johnson

Lacon

Known as

Deloise Johnson	F	l- For State Registrar	ate of Maryla		artment of <i>rtificate of</i>		and Me	ntal Hy		2 0 eg. No.	07	12565
Physicia	n/	 Decedent's Name (First, Midd 							2. Date of Dea Month			. Time of Death 1820 hrs
Medical Examir		Doloise Johnso 4a Facility Name (if not institution		mber)		1b. City, Town	n or Locatio	n of Death	April 15, 2	2007 4c. County o	f Death	1020 1115
		1206-C Littlebrook Dr	-	ilber)		Frederic				Frederic		
Funeral	٦	5. Social Security Number	6. Sex	7. Age (in yrs.	last birthday)	If Under 1		nder 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY	9. Birthp	place (State or
Director		237-66-2271	1 M 2 X F		65 Yrs		Days Ho	urs Min.	08/14	/1941	Coun	North ^(ry) Carolina
ž.	ļ	Usual Residence of Decedent 10a. State 10b. County		Inc. City	, Town or Locati	on						Od Inside City Limits
liow any			. 1-	100. 01.9								1 X Yes 2 No
ırylancı ia-f sh	함	Maryland Fred 10e. Street and Number	lerick		Fre	derick 10f. Zip Co			1	0g. Citizen of Wh	at Countr	y?
with the Maryland s 23a or 28a-f show a e notified at once.	Director	1206-C Little	Brook Driv	re		2170	02			United	Sta	tes
with ms 23.	뒱	11. Marital Status	Annual Co	edent Ever in U		s Decedent of es, specify C			ecify Yes or No	o- 14. Race White		n Indian, Black,
or ite	Funeral		1 Yes	2 X No					tiodii, oto.)	ŀ		
rs afte	솔	3 X Widowed 4 Div	or Dates:		16a. Deceden	Yes 2 X			ork done	Specify: 16b. Kind of Bu		lack
2 hours af "matural"	Completed	Elementary/Secondary (0-12)				ost of working						
5-0036 led within 72 tygiene. other than other Medical	힐	12			Secret	ary				Univer		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle	, Last)							Maiden Surname		
212 old be Mental marke	To Be	Edward Blount 19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (-1 111		Sykes	mber, City or Tow	n, State, Z	Lip Code)
and 2 shoul cealth and N ten 27 is n traumatic	-1	Stephanie John		hter	8011	Catta	il Ct.	, Fre	derick	, MD 217	01	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cost of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fro		Place of Dispos crematory or oth Res			Apr	il 20,	20c. Location -	City or To	own, State
Pages nent of ant: I		4 Donation 5 Other S			lemorial	Garde	ns		2007			Maryland
Baltimore, permit. Pages and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service	Licensee		Res	lame and Ado	dress of Fac n Fune	eral S	ervice	s, Skkot	Cod	y P.A.
Physician	11.5	23a. Parkil. Enter the disease, o	complications that ca	aused the death	1950	01 Cato	octin	Mtn.	Hwy. F	rederick	, MD	21701 Approximate Interval
/Medical	10	failure. List only one cause	on each line.								Į.	Between Onset and Death
Examiner		Immediate Cause (Fin I disease or condition resulting in death)	Due to (or as a									
		Sequentially list conditions,	b.	200200000000	of):						-	
	li.	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that mittailed										
√ ps tise	Exar	events resulting in death) Last	Due to (or as a	consequence	of):							
te be executed ysician and burial - transit	edical Examiner	X UNPENDED #23a,PII,27,perME, g866, 4/23/07 TT										·
60, ate be hysicia e buria		IF FEMALE:	23c, If yes,	outcome of pre		<u>. 4/23/C</u>)/ TT			23d. Date of	delivery	
687 ertific ding p	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specific)										
Box 6876 e death certificat the attending phy ed for use as the	Physician/M	1 Yes 2 🗸 No 9 Ur	nknown 9 Unkno		5 Of	her (Specify)			1		
, P.O. Box 6876 res that the death certificat signed by the attending ph. be detached for use as the	- 1	Part II. Other significant cond	itions contributing to	death but not	resulting in the	underlying ca	use given ir	Part I.		tobacco use contr		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rasther death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed by	Atheroscleroti	<u>c cardiovasc</u>	ular dis	ease	<u>.</u>				es 2 V No 3		
n of Vital Records ling Physician: The law requi After this certificate has been funeral director, page 2 should	plet			 					24a. Was	psy		psy findings available mpletion of cause of
tal Reco cian: The law certificate has	ĕ			_					1 🗸 Yes			2 No
ician: certif	Be (25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatien		Place of De		nly one)	Residence 6	✓ Other:	Scene
i of Vi ing Physi After this uneral dir	의	1 Yes 2 No 27. Manner of Death	28a Date	of Injury	28b. Time of		. Injury at W			how injury occur		
on Con conding ath	tion	1 Natural 5 Per	(Month ading	i, Day,Year)		1	Yes 2	☐ No				
ViSion Attender de Directo	ifica		estigation 28e. Plac	ce of Injury - At	home, farm, stre	et, factory, of	fice building	, etc.	28f. Location or Town,		er or Rura	al Route Number, City
Divinal ours at filled in	Certification:	4 Homicide det	ermined (Specify)									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed writin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying I Cone) 2 Medical Ex	Physician: To the beaminer: On the basis	st of my knowle	edge, death occu	rred at the tir	ne, date and pinion, death	place, and occurred a	due to the cau	use(s) and manne e and place, and o	r as stated due to the	d. cause(s)
To the within To the comple	Medical	29b. Signature and title of certif	and manner s	stated.			icense num			29d Date sign		
- A		Jashe	Heer	1 Mis			D.C.M.E.			April 16, 2	007	
2 of sol		30. Name and address of person										
1 2		Tasha Greenberg MI	D. Assistant M	ledical Exa	miner 111	Penn Str	eet, Balti	more, ME	21201			
St Regist	ate	31. Date filed (Month, Day, Year	2007 32 R	egistrar's Signa	ature	E.						

CRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene Per ME 3866,04/18/07dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death KIEL **Physician** 9:58 PM ROSE APRIL 2007 14 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2√√ July 21, 1929 Pennsylvania Director 217-26-2383
Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiens. 77 is marked other than "natural", or items 23a or 28a-f show 7.7 is marked other than "natural", or items 23a or 28a-f show traunatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21219 2417 Ketchum Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Specify. þ 3√Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should be of Health and Menta f item 27 is marked r other traumatic ev ပ Rose Ann Windsor James Henry Love, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2414 Suncrest Road Baltimore, Maryland 21219 Connie L. Bunn (Daughter) 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/17/2007 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SMALL BOWEL INFARCTION 2 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK 48 HOURS A PROVED BY MEDICAL EXAMINER Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sician and burial-transit that the death certificate be executed GASTRIC ULCER resulting in death) Last Due to (or as a consequence of) physician DAYS Physician/Medical CERTIFIC the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy page 2 No 1☐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Yes 2 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Medical Certification: Hospital or Attending Division 1 Natural 5 Pending 04/06/2007 11:00 p^M Subject fell 1 TYes 2X No death. investigation Director; / 2 X Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) building, etc. (Specify) home

201. Location, (Street and Number or Rural Route Number of Rural Route Number o 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES-000 APRIL 14, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL AWAD, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 1 8 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 06 40M FUOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOUNT wanty beneal Norpita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex / 14 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 71 1935 213-32-3066 May 10, Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "natural", or Items 23a or in any Injury or other traumatic event, the Medical Examiner must be none. 3004 North Ridge Rd. USA 1 14. Race - American Indian, Funeral 21043 12. Was Decedent Ever in U.S.
Armed Forces?

KF Yes 2 □ No 1957
KYes, Give
Year or Dates: 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White Specify. by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation

18. Mother's Name (First, Middle, Maiden Surname) Truck Driver 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be need of Health and Mental Milton J. Kick, Sr. Thelma E. Smith 19a. Informant's Name/Relationship (Type. Print)
Shirley A. Kick, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Elm Rd. Arbutus, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State West Arundel Crematory 04-18-07 4 □ Donation 5 □ Other (Specify) Odenton, MD 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Euneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Arbutus,

Approxima e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischen (**Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: **Hospital or Attending** 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Day,

APR 1 9 2007

31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7, 7:00 PM M April 2007 Anne F. Kennedy 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Lutherville Brightwood Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth (Month, Day, Year Months 1 ☐ M 2 👿 F 69 Oct 30, 1937 213-36-5546 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√∑ No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 Eastridge Road 21093 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Q. Feller Anna Marie Schneider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kennedy/daughter 2123 Eastridge Road Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street State Anatomy Board 655 W. B Baltimore, MD 21201

**A. Part. Enter the diserve, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or or dition resulting in death)

a. ARGE EU NG CANCER with Metaleurical Control of the control of Approximate
Interval Between
Onset and Death
A Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notifled at show

or Items 23a

72 hours after death

Baltimore, Maryland 21215-0036

68760

ENNEDY ANNE Division or Vital Records, P.

or Attending

7 is marked other than "natural", or Items 23a traumatic event, <u>the Medical Exa⊓iner must</u>

and Mental Hygiene.

Department of Health a Important: If item 27 is any injury or other tra-

permit.

Director

Funeral

ģ

Completed

Be

ပ

MD

and signed I d be det

attending physician for use as the buria by the page 2 s certificate

Examine Physician/Medical þ Completed Be ဥ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Medical Certification:

25. Was case referred to medical examiner?
1 ☐ Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16565 N. Charles St Suite 209, R raulkne 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 9 2007

and manner stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CUGENE 062VM 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner dena Anne Arundel Pasa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 09-03 9. Birthplace (State or Foreign **Funeral** Days Min 1 M 2 F Months Hours 50.663 Director Usual Residence of Decedent death with the Maryland 10a. State City, Town or Location 10d. Inside City Limits 10b. County 10c. or 28a-f show Examiner must be notified at Anne Arunde asadena 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tve 211 ,5. aa or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: ff item 27 ie marked other then "natural", or itei 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver 2 rucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ permit. Pages 1 end 2 shou Dapartment of Health and M Importent; if item 27 ie mar eny injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lebrun TILB Irch AVE 21122 awn 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 Removal from State Hanover 1-2007 4 Donation 5 Other (Specify) 21. Signa mera Service Licensee DAURHERTY ICHES HOME Part1. Enter the disease, or complications may caused to shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

(MUN) the death. Do ne ch as cardiac or resp Immediate Cause (Final disease or condition resulting in death) **Physician** WA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ettending physician Physician/Medical for use as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by tha should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificata has autopsy performent 1 Yes 2 No 1 Yes 2 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home St Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 Yes 2 🗌 No 2 Accident To the Funerel Director: , complataly filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Chief Medical Officer 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

n

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

APR 1 9 2007

31. Date filed (Month, Day, Year)

Hospice of the Chesapeake

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ORIGINIA

Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401

D 21438

07-02900 John Laucht Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

III Labori		- For State Certificate of Death											O Toronto Death
Physicia		egistrar 1. Decedent's Name (First, Middle,Last)									Year	3	. Time of Death 0919 hrs
Examir	er	John Laucht									. County of		
	4	4a. Facility Name (if not institution, give street and number) 1820 Spence Street Apartment 402 4b. City, Town, or Location of Death Baltimore						OI Death	N/A				
				7. Age (In yrs. las	t hirthday)	If Under 1		er 24Hrs.	8. Date of B	irth(MM/		g. Birth	place (State or
Funeral		. Social Security Number					Days Hour	s Min.	Feb 4	. 19	948	Foreign Cour	try) Mary land
Director		214-50-3683	1X M 2 F		9 Yrs.					.,			
any	<u> </u>	Jsual Residence of Decedent 0a. State 10b. County		10c. City, T	own or Location	on						- 1	10d. Inside City Limits
* ,		Maryland	N/A		Baltim	ore							1 X Yes 2 No
te Maryland or 28a-f show fred at once.	ま	Maryland				10f. Zip Cod	le	-		10g. Cit	izen of Wh		ry?
ith the Maryland 23a or 28a-f sho	Funeral Director	1820 Spence St	reet Apart	2		.230				US			
vith the s 23a e noti	핕	11. Marital Status	12. Was Dec	edent Ever in U.S	13 W/a	s Decedent o	f Hispanic O	ngin? (Spe	ecify Yes or N	No-	14. Race White		an Indian, Black,
eath r	nue	1 Never Married 2	Married Armed Fo	2 X No					,		Specify:	Whit	-6
after d	by F		ivorced If Yes, Give Yee or Dates:			Yes 2X			ork done	16b.	Kind of Bu		
ours a		15. Decedent's Education (Sp			16a. Deceden during m	rs Usual Occ ost of working	life. DO NO	T use retir	red)	100.			,
6 n 72 h an "r ical E	Completed	College (1-4 or 5+) 8 College (1-4 or 5+) Truck Driver							Truck				ng
withingiene.	E.	17. Father's Name (First, Middl	e Last)				18.Moth	er's Name	(First, Middle	e, Maide	n Surname)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Kennard Lau						Doro	othy C	urr <u>a</u>	ın		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menla Hygieneth and Manal Hygieneth are 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relation	nship (Type, Print)						Rural Route N				04440
nore, MD 21215-0036 ages I and 2 should be filed within 72 he in of Heath and Mental Hygiene. It: If item 27 is marked other than "na other traumatic event, the Medical Ex		Robert Parl	ks, Brothe	<u> </u>					e Ct.	#103	Oder	ton.	MD 21113 Town, State
G, C, L, and I and I teal		20a. Method of Disposition 1 Burial 2 X Cremati	on 3 Removal fr	_	Place of Dispos rematory or ot	her place)	or cemetery,					-	
Pages ent of int: I		1 Burial 2 X Cremati 4 Donation 5 Other		Met	ro Cre	matory	Inc.	04/	18/07	Ba	altim	ore,	Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within pegarment of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	- 3	21. Signature of Funeral Servin	ce Ligensee		22.1 Cr	Name and Ad ematic	dress of Fac n Soc	ility iety .	Of Mar	ylaı	nd, I	nc,	nd 21228
@ 5.5 5.5		Thomas Grego 23a. Part I. Enter the disease,	r 0	award the death	Do not enter	9 Fred	lerick Iving, such a	KOAO s cardiac o	r respiratory	arrest, s	e <u>Ma</u> shock, or he	CV La	Approximate interval
vsician		 Part I. Enter the disease, failure. List only one cau 	se on each line.				,,						Between Onset and Death
` ≀edical ⊏xaminer		Immediate Cause (Final disea or condition resulting in death		tyline int		on							
			b.	a consequence of	.,.								1
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence o	f):								
_	Examiner	cause. Enter Underlying Cau (Disease or injury that initiated	Due to (or as	a consequence o	f):								
msi ted	Exa	events resulting in death) Las	d.										
execu	ical	X UNPENDED	100	'II,27,28a-	-f nerMi	E 0866	4/26/0	7 TT					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commelete filled in whe fineral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:		, outcome of preg	nancy						23d. Date Month		y Day Year
587 crtifica ling p	an/I	23b. Was decedent pregnant i past 12 months?		birth anant at time of de		etal death		opic pregn	nancy		MOITH		bay .ca.
Sox 687 leath certific e attending F	Physician/	1 Yes 2 No 9	University of the Control of the Con	nown	eath 5 (Other (Specif	y)			-			
5.0. By that the denoted by the	P.	Part II. Other significant cor	nditions contributing	to death but not r	resulting in the	underlying	ause given i	n Part I.					the cause of death?
, P.C ires that signed l	र्व	Hepatic steate							. 1	Yes 2	2 V No		III.
ds, equire een si	eted								l a	Nas an autopsy	1	prior to	utopsy findings available completion of cause of
COF lawr has b	Completed by									erforme /es 2		death?	res 2 No
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. The Funeral Director: After this certificate has been is completely filled in by the funeral director, page 2 should	និ	26 Place of Death (Check only one)											
'ital sician is cert irecto	l a	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Other	4 Nurs	sing Home 5		sidence 6		er: Scene
of V g Phy her th	<u>ا</u> ا	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury nth, Day, Year)	28b. Time o	f Injury 2	3c. Injury at \		28d. Desc	ribe how	v injury occ	urred	
OD canding ath.	ţį.		Pending Fnd	4/16/2007	Fnd 9:0	00 am	1 Yes		unk			.1 5	Dural Boute Number City
r Attorier de irecto	fica	v	Could not be 28e. Pl	ace of Injury - At			office buildin	g, etc.	or To	wn State	e) 1870	Sper	Rural Route Number, City nce St. Apt. 40
Dital o	Certification:	4 Homicide		y Found: 1					Balti			.ZZ9	atad
Hosp 24 ho Fune	ia Si	29a. Certifier 1 Certifyin	ng Physician: To the b Examiner:On the bas	est of my knowle	dge, death oc	curred at the gation, in my	time, date ar opinion, dea	id place, a th occurre	nd due to the d at the time,	date and	d place, an	d due to	the cause(s)
To the within To the	Medical		and manne	r stated.			License nur						fonth, Day, Year)
	ĮΣ	29b. Signature and title of de	eruiter	Λ			O.C.M.E				April 17,	2007	
W A	3	11/1	AN V	/	032								
18,01	1	30. Name and address of pe	rson who comite ed c Assistant Med	ause of death (Ite dical Examine	mi∠3a) er 111 P	enn Stree	t, Baltimo	re, MD 2	21201				
'		Susan Hogan MD. 31. Date filed (Month, Day, Y		Registrar's Signa									
Reg	State istra	ADD	/	Benever .	Jr. s	most?)						
DHMH 17 Rev			P	A 410 0	ORIGII	NAL							

Richard Lomas

07-02575 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	0	- 3	ineg	4	1	-	4
2	1	1	1	1	1	5	- /
form.	U.	الي	1	i	(v)	- 1

		- For State Registrar			Certif	ficate of	Death		R	eg. No.	107 1	(U 1
Physicia	n/	1. Decedent's Name (Firs)	_					th Day Year	3. Time of D	
Medical Examin		Richar			Lomas					007	1023 M	rs
j		4a. Facility Name (if not in Ocean Gateway	· -	Bryan Road			b. City, Town, or Trappe		th 4c. County of Death Talbot			
Funeral Director		5. Social Security Number 122-38-47	10	x 7.	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day			th(MM/DD/YYYY) 8,1949	9. Birthplace (State Foreign Country W	
2		Usual Residence of Dece									10d. Inside (City Limits
w any			County airfi	5.10		wn or Location	n				1 X Yes	
yland 1-f sho	핡	CT. F	allil	eiu	Stan	11014	10f, Zip Code			0g. Citizen of Wha		
72 hours after death with the Maryland n"natural", or items 23a or 28a-f show at Examiner must be notified at once.	Öİ	204 Guinea Road 06903								USA		
eath with the items 23a	Funeral	11. Marital Status 1 Never Married 2	2 XMarried	12. Was Deced			Decedent of His s, specify Cubar		Specify Yes or No erto Rican, etc.)	14. Race - White		lack,
after de	절	3 Widowed 4	Divorced	1 Yes If Yes, Give Year or Dates:	2 <u>A</u> NO	1	Yes 2 X No	specify:		Specify:	White	
nours a	a l	15. Decedent's Education		lly highest grade			s Usual Occupa st of working life			16b. Kind of Bus	siness/Industry	
5-0036 ed within 72 hours afterlygiene other than "natural", the Mydie al Examine	ornpleted	Elementary/Secondary	r (0-12)	College (1-4	or 5+)	Pr	incipal	l	·	Heatin	g & Air	
d with giene ther it	ĕ	17. Father's Name (First,	Middle, Last)						me (First, Middle,	Maiden Surname)		
21215-0036 suld be filed within 7 Mental Hygiene marked other than re event, the M dis	Be C	James Lo	James Lomas Florence Marletti a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 06903									
, MD 21215-0036 and 2 should be filed within tealth and Mental Hygiene tem 27 is marked other tha traumatic event, the M. dis	2	19a. Informant's Name/R	elationship (T	ype, Print)		19b. Mailing	Address (Stree	et and Number	or Rural Route Nu	mber, City or Town	n, State Zip Code)	
ore, MD es I and 2 sho of Health and If item 27 is her traumati		Allison L		Wife	Joh Bla		Guinea tion (Name of ce		Stamfo Date	rd, Conn	ecticut City or Town, State	
es – se r		1 X Burial 2 Cr 4 Dogation 5 C	remation 3		- Crea	matoni or oth	or niace)	• •	4/12/07		nwich, C'	т.
Baltimo permit. Pag Department Important: injury or ot	t	21. Sign re of Funeral	Servize Licen	see		22. N	ame and Addres	s of Facility	DT FUNE	RAL SER	VICE, P.	Α.
		/ Huly l	Rule	~	and the death D	92	41 Coli	ımbia_	Blvd.Si	lver Sp	ring Md	20910
Physician M i		failure. List only on-	My Multiple Injuries 9241 Collumbia Blvd Silver Spring Md20910 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lure. List only one cause on each line. Multiple Injuries Death Province Provin									
Examiner		Immediate Cause (Final or condition resulting in		Multiple Injur Due to (or as a co								
		Sequentially list conditio	ь									
	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):											
red msit	Examiner	(Disease or Injury that in events resulting in death		Due to (or as a co	onsequence of):							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	/Medical	UNPENDED		AMENDED								
8760, ificate bong physicals the bun	Ž.	IF FEMALE: 23b. Was decedent pregr	ant in the	23c. If yes, ou	tcome of pregnai h		al death 3	Ectopic pre	gnancy	23d. Date of Month	delivery Day	Year
Box 68 c death certif the attending ed for use as	Physiciar	past 12 months?	Lielengue	4 Pregnar	it at time of death	_	ner (Specify)					
. Bo he dea y the a	hys	Part II. Other significan		o		ulting in the u	nderlying cause	given in Part I	23e Did	obacco use contri	bute to the cause of	death?
ords, P.O. Box 68 w requires that the death certif s been signed by the attending	Ď	Fait II. Other significan	Conditions	contributing to c	eath but not rest	anting in the d	nderrying oddoo	givonini			Probably 4	
ds, equire een sig	Completed						<u>-</u>		24a. Was		Vere autopsy finding	
COT law r has b	m ple		 _							ormed? d	rior to completion of leath? Yes 2	No No
tal Rec		25. Was case referred to	medical				26.Plac	e of Death (Che		2 10 1	V 163 2	
Vital hysician: this certif	o Be	examiner?	_	Hospital: 1 Inp	atient 2 E	R/Outpatient	3 DOA	Other Nu	rsing Home 5	Residence 6	Other: Scene	
Division of Vital Records, tal or Attending Physician: The law requints after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	,— h	27. Manner of Death 1 Natural 5	Pending	28a. Date of (Month D Apr 4, 200	Injury 2 lay,Year) (8b. Time of I 0945 hrs		ury at Work? Yes 2 ✔ No	Dassenger	how injury occum in plane cras		
ivisior or Attendafter death Director:	Certification:	2 🗸 Accident	Investigat	28e Place	of Injury - At hom	ne, farm, stree			28f. Location		er or Rural Route Nu	umber, City
Div pital or ours after reral Dir filled in	ertif	3 Suicide 6 Homicide	Could not determine		Field				or Town, Ocean Gate	State) way @ Buck Bry	an Road, Trappe	, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Cert (Check only one) 2 Med	ifying Physic ical Examine	r:On the basis of	examination and	, death occur l/or investigat	red at the time, o ion, in my opinio	date and place, on, death occurr	and due to the car ed at the time, date	use(s) and manner e and place, and d	as stated. lue to the cause(s)	
To the within To the comple	Mec	29b. Signature and title	of certifier	and manner sta)		29c. Licen	ise number		29d. Date sign	ed (Month, Day, Yea	ar)
		HIK	1 X	VX 6			O.C	.M.E.		April 5, 200)7	
- N		30. Name and address of					n Street D-	Itimoro MD	21201			
ľ	لبي	Susan Hogan N	_	istant Medica	À		n Street, Ba	iumore, MD	21201			
St Regist	ate	31. Date filed (Month	R'1 9 2	007	istrar's Signatur	Signal .	ALS.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{¥ear} **Physician** 10:45 am Joseph J. Liberatore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore 1510 Customs Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Mary land Days Hours 7729/1930 1**X** M 2□ F 76 212-26-8704 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21237 1510 Customs Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 🛛 No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoreman Linesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Molinari Dominick Liberatore P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 Customs Road Baltimore, MD 21237 19a. Informant's Name/Relationship (Type. Print) Geraldine Liberatore/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2007 Baltimore, Maryland Sacred Heart Jesus 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral S Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death marco Immediate Cause (Final CM con 3 m ~ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate dause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Restdence 6 Other (Specify) 1 | Yes 2 | 1 | Yo 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ospital o.
4 hours after deau..
-*al Director; Afte 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Fosten 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Lewis, Elizabeth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and 1 - State Registrar Certificate of Death		iene 007	12573
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth C. Lewis	2. Date of Death Month April		3. Time of Death
	/Medic Examin				4c. County of Deal Harfo	
la 	Funeral Director		219-07-31/2 10 M 204 P 88 Yrs.	Hrs. 8. Date of Birth Min. 03-31-1	9. Bin 919 Mar	thplace (State or Foreign ountry) 'Yland
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford Abingdon			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the	Funeral Director	106. Street and Number 450 Clybebenk Drive	10	0g. Citizen of What Co	ountry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Merital Hygiene. item 27 le marked other than "naturel", or flema 23s or 28e-f ehow other traumatic event, the Medical Examinar must be codified at	by	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☑ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	filed within 72 ho Hygiene. other than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baker	working	16b. Kind of Business. Food Indus	,
Maryland 2	2 should be filed and Mental Hygic le marked other surmatic event, II	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, N leline Ross		
	ss 1 and 2 sho of Health and I item 27 le ma		19a. Informant's Name/Relationship (Type, Print) Linda Lee Ocampo - Daughter 19b. Mailing Address (Street and Number of 450 Clybebenk Drive)	Abingdon	, MD 21009)
Baltimore,	pernit. Pages 1 Dep-riment of H Importent: If ites any injury or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 04	/21/2007 Ba		Maryland
Bal	Departiment Important Impo		21. Signature of Funeral Service Jicensee 22. Name and Address of Facility Leonard J. Ruck,			Road ryland 21214
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Avest Fitian		Approximate Interval Between Onset and Death
>60928	cate be executed physician and the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			3 months 1 year
.O. Box 68	The law requires that the death certification has been signed by the attending plange 2 should be detached for use as t	Physiclan/Med	D The state of the		23d. Date of de Month	livery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part ii. Other significant conditions contributing to death out not resulting in the underlying cause given in Part i.	23e. Did tob	pacco use contribute to	o the cause of death?
Vital Records,		Completed		24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
	Physician: Th this certificate ral director, pag	To Be	examiner? Types 27No Hospital: 1 Innation: 2 ER/Outpation: 3 DOA Other: 45 Nursure	Death Check only one ng Home 5 Reside		ecify)
Division of	ttending death. tor: After	Certification:		28d. Describe ho 28f. Location (Str. City or Town	reet and Number or Ri	ural Route Number,
Ö	To the Hospitef or A within 24 hours after To the Funeral Direct completely filled in by			lace, and due to the ca	ause(s) and manner as	s stated.
\ \	To the Parity of To the P	Medical		29	9d. Date signed (Mont	th, Day, Year)
7	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Senjamin Lee, MD (Xo9 Revolution St. Hove	o do C	1/10/20	21078
· F	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ac Grace	(MD 0	21010
DI	IMH 17 Rev 1/2	- marij	73: 11 2 9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 12:35AM 2007 04 James P. Lazzati 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GOOD SAMARITAN HOSPITH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Apr. 16,1917 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Months Days Hours 90 216-01-5258 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 1 □Yes 2 No Towson Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 #507 2 Southerly Court Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Snecify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Supply Contractor President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Ertola Giacomo L. Lazzati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 533 St. Francis Road; Towson, MD 21286 son Philip L. Lazzati 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/21/07 Baltimore, MD New Cathedral Cemetery 1050 York Road 21. Signature of Fun rai Service Licerisee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RES I IXHTOK disease or condition resulting in death) Due to (or as a consequence of): PNOUNONIA ASYTKITIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULHONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe HYPOTHYRODINI 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Umpatient 2 ER/Outpatient 3 DOA 2 No 1 ☐ Yes

Physician /Medical Examiner

and

attending physician

use as the burial-tra

be detached

page 2

Certification: To Be

Medical

certificate

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

or Attending Physician:

Division

signed by

The law requires that the death certificate be executed

or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines any.

Director

Funeral

Completed by

Be

ပ

MD

death with the Maryland

Maryland 21215-0036

Baltimore,

AZZATI

Examiner Physician/Medical IF FEMALE: Completed by

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending investigation

6 Could not be determined

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

2ES000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAYAKITAN HOSPITAL BALTIMORE 600D

A160 MHRWAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

			For State Registrar	State of Marylar		artment of H rtificate of L		F	Reg. No.	7 12575
	Physicia	an	1. Decedent's Name (First, Middle,					2. Date of Dea Month April 1		3. Time of Death 10:30 a M
1.0	/Medic	al	Alice 4a. Facility Name (If not institution,	Olivia Lake		4b. City, Town, or	Location of D		4c. County of	
7 *	Examin	er	1325 Deanwood F			Parkvi				imore
费	Funeral Director		069-12-8049	i. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Min. Sept 5,	, 1919 .	9. Birthplace (State or Foreign County) Jamaica
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Le	ocation				10d. Inside City Limits
	Maryl	tor	MD Bal	timore	Park	ville				1 □Yes 2X No
	with the a or 28s	Direc	10e. Street and Number 1325 Deanwood	Road		10f. Zip Code 21 23	34		10g. Citizen of W	hat Country?
	ne 23	erai	11. Marital Status	12. Was Decedent Ever in U	.S. 13.			? (Specify Yes or No- uerto Rican, etc.)	14. Race	- American Indian,
920	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Experiment must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Yes, specify Cuba	Specify:	ueno Rican, etc.)	Specify:	, White, etc. Caribbean merican
2-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occupa	during most of	working	16b. Kind of Bus	siness/Industry
21215-0036	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	_		Nurs	ina
0	Hygie Hygie other ant, II		17. Father's Name (First, Middle, La	ast)	1 1 1 1 0 0			Name (First, Middle,		
/lan	Mental Mental arked attc av	To Be	Се	Chen			Mau			rgan
Maryland	od 2 sho lith and 27 is ma traumi		19a. Informant's Name/Relationshi			-		r Rural Route Numbe Parkville		State, Zip Code) 1234
nore,	ages 1 ar nt of Hea t: If item f or other		20a. Method of Disposition 1 Burial 2 Cremation 3	B □Removai from State	cemetery, cre	osition (Name of matory or other place Serv Corp		Date r.20,2007	20c. Location - С	City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any figury or other traumatic avant, the Medical Experiment must be notified at ODGs.		4 Donation 5 Other (Special Service Line)	,,	au ²	2. Name and Addres	ss of Facility			l home, Inc.
,092	Physician /Medical Examiner physician and physician the private physician side physician physici	cal Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	quence of):	r		0 0		Approximate Interval Between Onset and Death 5 4/43
P.O. Box 68	death certific e ettending p id for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☒No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fet} \) 4 \(\subseteq \text{Pregnant at time of} \) 9 \(\subseteq \text{Unknown} \)	al death 3	□Ectopic pregnancy	′		23d. Date Mon	o of delivery th Day Year
	uires that signed by id be deta	þ	Part II. Other significant condition	s contributing to death but not re	sufting in the	underlying cause giv	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed						24a. Was autop perio 1 □ Yes	osy p ormena? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 \sum No
/ita	Phyaician: This certifical	Be (25. Was case referred to medical examiner?	Heaviel		104		Death (Check only of		
of\	w 5	-T	1 Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatie			ng Home 5 Resid	dence 6 Othe	
on	iding Phi th. After thi funeral	tlon	1 Natural 5 Pending 2 Accident investigs		Injury	Wor	k? Yes 2 ☐ No		,,	
Divisi	il or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not determine	ot be 280 Place of Injuny - At I	nome, farm, s ify)	treet, factory, office		28f. Location (3 City or Tou		er or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C		Physician: To the best of my kr xaminer: On the basis of examin and manner stated.						
	within comp	₩ E	29b. Signature and title of certifier	۸ .		29c. Licens				(Month, Day, Year)
)	1		DJ. Croston C	Honovan, MD		1900	7633	2_	04-18	-2007
	9		30. Name and address of person w	NOVAN MD 2	m 23a) (Type	O, Print) OUNDALK	AVE.	BALTO.	mD	21222
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	the completed cause of death (Ite OUNN M) 2 32. Registrar's Sign 1 9 2007	ature	france				

.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
State of Maryland /	Department of H	ealth and Menta	I Hygiene

		4	For State	State of		d / Depa		t of H	ealth a		tental Hygi	ene U	07	12576
			Registrar 1. Decedent's Name (First, Middle, La	st)			uncare	5 01 2	Jean		2. Date of Death	g. No.		3. Time of Death
	Physici	an	LEONARD I	•	F						Month	Day	Year 7	3:15 A M
	/Medic		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of	of Death	Whiti I	16, 2007 3:15 A M		
	Examin	eı	MANOR CARE, RUX		,		_	owsc						e County
	Funeral Director		5. Social Security Number 6. 5		Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Feb 18,	1925	Cor	aplace (State or Foreign untry) rvland
	o		Usual Residence of Decedent											
	how	_	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🕅 No
:	8a-1	Director	Maryland Baltimor	e County		Balt	imore							
	Mith I		10e. Street and Number	т			10f. Zip		21209		10	g. Citizen of		untry?
	eeth	eral	2164 Charles He	12. Was Deced	ent Ever in U.	S. 13.	Was Deced			gin? (Sp	ecify Yes or No-		USA se - Amer	ncan Indian,
ဓ္ဌ	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. and Mental Hygiene is marked other then "natural", or items 23e or 28e-f ehow aumatic event, in a Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 ♥ Widowed 4 Divorced	Armed Forc	es?	1	ffYes, spec 1 ☐ Yes 2		n, Mexican Specify:	i, Puerto	ecity Yes or No- Rican, etc.)	Bla Specil	ck, White	h, etc. Thite
	tural'	b p	15. Decedent's E	1	8S: 4J=4(1	dent's Usua	if Occurs	ation		1	6b. Kind of B	usiness/l	ndustry
5	in 72	plet	(Specify only highest gr	ade completed)	10.5.1	16a. Dece (Give life.	kind of wor DO NOT us	rk done d se retired	luring mos	t of work	ing	00. 140 0. 2		
Maryland 21215-0036	r the	Completed	Elementary/Secondary (0-12) 8th	College (1-4	or 5+)	Carp	enter	•				Cons	truc	tion
<u> </u>	al Hygie other	Be C	17. Father's Name (First, Middle, Las	')					18. Mothe	r's Nam	e (First, Middle, M	aiden Sumar	ne)	
<u>a</u>	Mental Mental arked o	10 0	James		Logue					Agne	S	Mc	Evoy	
a	and le mu	1 8	19a. Informant's Name/Relationship				3				al Route Number,	•		
o)	and fealth m 27 her tr		Lisa A. Logue	(Daug	hter)	2164	Char	les	Henry			Lmore, Oc. Location		yland 21209
0	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			lace of Dispo emetery, crei					_			
Baltimore,	rtmen rtant: rtant:		4 ☐Donation 5 ☐ Other (Special	1	Net									Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		21. Signatur of Funeral S Co lies Martin D. Lav	son	add7						FUNERAL ltimore,			
			23a. Part1. Enter the disease, or con shock, or heart faiture. List only	plications that cau	used the death	n. Do not ent	ter the mod	e of dying	g, such as	cardiac	or respiratory arre	st,		Approximate Intervat Between
F	Physician		Immediate Cause (Final disease or condition	12	-7	1)34	TER	5,2			SEAS			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	r as a consequ	uence of):								
	=xammer		Sequentially list conditions,	b		- 41								
7	pet isr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ras a consequ	Bence ory.								
	e be executed /sician and e burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or	r as a consequ	uence of):								
	Ψ - Ψ	cal		_ d										
9	leati certificate ettenoing phy. I for use as the	Medi	In the second of											
ŏ	tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outco	me of pregna		∃Ectopic pr	egnancy					ate of deli	
P.O. Box	the et the et thed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of de m		Other (sp.					IVI	onur	Day Year
٠.	thet the di ed by the detached	F.	Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the u	nderiving c	ause give	en in Part I.		23e. Did toba	acco use con	tribute to	the cause of death?
ds,	w requires the been signed should be det	d b					, ,				1 ☐ Yes	2 □ No	3 🗆 Pro	obably 4 Unknown
Ö	w req	lete									24a. Was an	24b.	Were au	topsy findings available
æ	helav ehas age 2	Completed									autopsy perform	ed2	prior to c death?	completion of cause of
<u>ra</u>	an: I tificat tor, pa	0	25. Was case referred to medical						26. Place	of Deat	1 ☐ Yes 2 h (Check only one	2 No	1 🗆 Yes	NO NO
>	ysici is cer direc	To B	examiner? 1 ☐ Yes 25 No.	Hospital: 1 Inp	patient 2	ER/Outpatier	nt 3 DO	Othe			me 5 Resider		ner (Spec	cify)
0	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	tnjury Day Year)	28b. Time o	1 2	8c. Injury Work	/ at		28d. Describe how			
Sio	endii eath. or: A the fu	catle	2 Accident investigation				М	10	Yes 2	No				
Division of Vital Records,	after d after d Direct d in by	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	280. Place o	f tnjury - At ho g, etc. (Specify	ome, farm, sti y)	reet, factory	, office			28f. Location (Str. City or Town,		ber or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the deatll certifical within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the b miner: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the car red at the time, da	use(s) and m te and place,	anner as and due	stated. to the cause(s)
	ro the within 2 Fo the comple	Med	29b. Signature and title of certifier	and manne	or stated.	M	290	. License	e number	_	29	d. Date signe	ed (Monti	n, Day, Year)
			Dovora	TIZ -	e e	~	パー	DZ	216	38	0	4/1	7	2007
	5		30. Name and address of person who						-	7.,	100	21.000	1	
	Sta	te.	HOWARD COHEN, 1	0480	1 0			enue	е, Ва.	LC1M	ore, MD	21208		
d,	Registr		APR 1 9 20	007	gistrar's Signa	1300	MEL D							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) [□]1 2007 6:55 p м April Martin Ann Aves 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number Days Hours Months JAN 28 1935 1 M 2 F 72 378-34-5735 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County 1 ☐ Yes 2 No Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 USA 8717 Hayshed Lane, Apt. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 5+ Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Walker Wesley Aves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 19a. Informant's Name/Relationship (Type. Print) 8717 Hayshed Lane, Apt. 13, Columbia, Maryland Donald Martin - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/18/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Society of Maryland, Inc. 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Dris Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use as the burial-transit

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r 28a-f show

"natural", or items 23a or

er than "natur the Medical

Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tt once.

Directo

Funeral

þ

Be Completed

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner cal

Hospital or Attending Physician: The law requires that the death certificate be executed thours after death.

Funeral Director: After this certificate has been signed by the attending newsign and

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division or Vital Records, P.O. Box 68760,

ed										
sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year								
, Phy	Part II. Other significant conditions		o use contribute to the cause of death?							
d by	Compostive Lung dis 20	u 1 □ Yes	2 No 3 Probably 4 Unknown							
Completed	leng dise.	24b. Were autopsy findings available prior to completion of cause of death?								
Be (25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing H	er: 4 Nursing Home 5 Residence 6 Other (Specify)						
ation: 1	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred					
ertific	3 Suicide 6 Could not t 4 Homicide determined		actory, office	28f. Location (Street City or Town, St	a <i>nd Number</i> or Rural Route Number, ate)					
dical C		Physician: To the best of my knowledge, death occu aminer: On the basis of examination and/or investig and manner stated.								
Ne Ne	29h Signature and title of gertifier	1 50	29d.	Date signed (Month, Day, Year)						

State Registrar

29b. Signature and title of gertifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Herbert Joseph Menard 18, April 2007 4:50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise Assisted Living Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 XM 2 ☐ F 015-03-4075 93 19, 1914 Director Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6500 Freetown Road 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Antique Dealer Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant; if item 27 is marked oth Be Joseph Alexander Menard Ida Herrold if item 27 is marked or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John H. Menard Son 1502 Covington Drive; Brentwood, TN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or 5 ther (Specify) Meadowridge Mem. Park 4/20/2007 Elkridge, MD 4 ☐ Donation 22. Name and Address of Facility terling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature Jun I Service Lio ee 1630 Edmondson Avenue; Catonsville, implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Deathy Poter the di isease, or complications that caused the liure. List only one cause on each line. 23a, Part1. shock, or heart fa Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760, Physician/Medical as signed by the attending place as leading place as as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 this certificate 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ဂ္ within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

9

2007

ÖRIGINAL

DHMH 17 Rev 1/2001

Registrar

- 1	11	Sec. rep.	0	- (**
- 6	12	horag	3.5	i
1	1	2.1	U	щ
	71.100	40.00	-	

	1	For State Registrer	State of Maryl		tificate of l		R	eg. No.					
Physiciar /Medica	1	. Decedent's Name (First, Middle, La	Dorothy M	Montag	gue		2. Date of Dea Month April	Day Ye 14 20	3. Time of Death 07 6:00 P.				
Examine		a. Facility Name (<i>If not institution, gi</i> Harbor Hospit			Balti			4c. County of E					
uneral irector		217 16 4244	1 M 2 THE	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 6		Birthplace (State or Foreig Country) Maryland				
f show		Usual Residence of Decedent 10a. State 10b. County 10a Anne	Arundel 10c.	. City, Town or Lo					10d. Inside City Limit				
sa or 28a-f si it be notified	2	10e. Street and Number 613 Hammonds I	ane		10f. Zip Code	225		10g. Citizen of Wha	•				
oriants if them 21 marked other than "natural", or items 23s or 28s4 show injury or other traumatic avent. The Madical Examinational be notified at the injury or other traumatic avent. The Madical Examination of the Injury of Transfer To Commission by Engage Injury of Transfer Injury o	Dy runera	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White				
than "natural in Medical is	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 9th	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired emaker	during most of work	ing	16b. Kind of Busin	ess/Industry Home				
7 Is marked other than " traumatic avent, Ins Mark	20 20 01	17. Father's Name (First, Middle, Las	ard H. Johnsto	on			e (First, Middle, 1i11er	Maiden Surname)					
27 Is mari		19a. Informant's Name/Relationship Juanita Curley			ng Address (Street Regatta A			r, City or Town, Sta re, Maryl	te, Zip Code) and 21225				
Important: If itam 27 is any injury or other trau		1 ☐xBurial 2 ☐ Cremation 3	☐Removal from State	cemetery, crei	matory or other plac	(e)			y or Town, State e, Maryland				
Importa any inju once.	20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 21. Signatore of Funeral Service 22. Name and Address of Facility 3 Removal from State 4/18/2007 Baltimore 22. Name and Address of Facility 4001 Kitchie Highway Baltimore, Mar												
vsician ledical aminer	Examiner	23. art1. Enter the disease, or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of Johnson Cause (Disease or injury that initiated events resulting in death) Last	_a Mujock	nsequence of):	1082	nction			Interval Between Onset and Death				
g physicias the bu	Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	d	egnancy Fetal death 3[□Ectopic pregnanc; □ Other (specify) _	,		23d. Date o Month	f delivery Day Year				
s been signed by should be detac	d by Pr	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause giv	en in Part I.		obacco use contribu ⁄es 2 □ No 3 (te to the cause of death				
ate has bee page 2 shor	ompiete							rmed? prio	r to completion of cause th? Yes 2 \sum No				
fter this certifiineral director	10 Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Yea		of 28c Injur Wo M 1	4 Li Nui sing H	ome 5 Resid	dence 6 Other					
	Certification:	3 Suicide 6 Could not determine	building, etc. (S)	pecify)			City or Tov	vn, State)	or Rural Route Number,				
To the Funa completely fil	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex 29b. Signature and title of certifier	Physicien: To the best of my aminer: On the basis of exa and manner stated.	y knowledge, deal mination and/or ir	th occurred at the tinvestigation, in my o	ppinion, death occur	rred at the time,	date and place, and	I due to the cause(s)				
, co	-	29b. Signature and title of certifier	· ·	<i>D</i>	7	53467		4/16	(07-				
			o completed cause of death						21061				

				Plea	ase 7								Ensure A			m m	ble.	1258
			For State Registrer			Otate t), IVIC	ii y tari		•			Death	norman i	Reg. I		0 1	
			Decedent's Nam	e (First, Midd	le, Last)								2. Date of	f Death			3. Time of Death
	Physici /Medio		Margare	t		Ε.		Man	gan					Month April		2007	Year	5:30 p
)	Examir		4a. Fecility Name (If not institution					Ü	4b.			Location of Death	_		4c. County		
			3121		+	MEAD							TIMOR			BAC		ore
	Funeral		5. Social Security N		6. Se	x ⊒M.2√2∏F		(In yrs. I	las <i>t birthd</i> Yr:	Mon	nder 1 Y ths D	ear_ ays	If Under 24 Hrs. Hours Min.		Day, Yes		Coun	,,
L.	Director		474-16-5 Usual Residence of			- 1	3	35		,				Oct.	13,	1921	_Minr	esota
	and **		10a. State	10b. Count	,			10c. City	, Town o	r Location							1	Od. Inside City Limit
	Varylan f ehow	ō	Maryland	Balti	mor	е		Ba1	Ltimo	re								1 ☐ Yes 2 ☐
	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23e or 28e-1 ehow he Medical Examiner roust by notified at	by Funeral Director	10e. Street and Nu	mber						10	. Zip Co	ode			10g.	Citizen of	What Coun	try?
	3a or		3121 Gre	anmaad	Ro	ad					2124	1/1				USA		
	deeth me 2:	era	11. Marital Status	Cimeau	I	12. Was Dec	edent E	Ever in U.	S.				ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes o		14. Rac	e - Americ	
(0	iffer of the control	Ē	1 Never Man	ried 2 ☐ Ma	rried	Armed F 1 ☐ Yes	2 (J-N	lo			specify as 2	_		Hican, etc.	.)		ck, White,	
93	ours a	þ	3 ∰Widowed	4 □Divorce	d	If Yes, G Year or I	Dates:			1 LJ Y	s 21_] NO	Specify:			Specif	y Whi	te
21215-0036	72 ho natur	Completed	(Spe	15. Decede)		16a. D	ecedent's Sive kind o	Usual C	ocupa done d	ation during most of work f)	ing	16b	. Kind of B	usiness/Ind	dustry
2	thin .	혍	Elementary/Seco	, , ,	3.22	College	-	+)	\ li	fe. DO N)T use r	retired)					
2	ygier t. th	ပွဲ	12_							Ass	emb1	er					Plar	ıt
pu	tai H d oth	8	17. Father's Name	(First, Middle	_		_						18. Mother's Nam	_	ddle, Maid	ien Sumar		
Maryland	should be filed within and Mental Hygiene. • marked other then "	2	Walter		R.		Jo	ohnsc					Elizal					sen
Jar	2 sho		19a. Informant's N				h	-1			,		and Number or Rui			•		Code)
	ss 1 and 2 should be filed within 72 hours after deeth with the Maryla of Health and Mental Hygiene. I feem 27 ie marked other then "natural", or iteme 23a or 28a-1 ehov rother treumatic event, the Medical Examinarimatic		Francin		wan	(Daug	nter			isposition			d Rd., Ba	Date			- City or To	um State
Baltimore,	permit. Pages 1 Department of the important: If Ite eny Injury or ot ance.		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation			n State	C	emeterv.	crematory e Cr	or othe	r plac	y @ 4/14					Maryland
a E	mit.		21. Signature of F	uneral Service	Licens	600			_				ss of Facility Lo	oudon				
8	Depa impo eny le		n		-					362	iW C	11k	ens Ave.	, Balt	imor	e, MD	2122	29
			23a Part I. Enter	the disease, o	r comp	dications that	caused each lin	the death	n. Do no	enter the	mode o	of dyin	g, such as cardiac	or respirato	ry arrest,			Approximate Interval Between
	Physician		Immediate Cause disease or conditi	(Final	, ,				ST	CA	NC	E	R					Onset and Death
1	/Medical		resulting in death)			Q		a conseq			,,		•					
	Examiner		Sequentially list co	on ditions		b												
	/D =	ner	if any, leading to in cause. Enter Und	mmediate	,	Due to	o (or as a	a conseq	uence of)	:								
1/	icate be executed physicien and s the burial-transit	Examin	Cause (Diseese or that initiated event	r injurý ts	•	c												
O.	e exe		resulting in death)	Last		Due to	o (or as a	a conseq	uence of)	:								
68760	ate by nysic he bi	ca			•	d												
39	leath certificate be attending physicie I for use as the bu	Med	IF FEMALE:														1	
Box	ith ce	an/	23b. Was deceder	nt pregnant		23c. If yes, o 1∐Live		of pregna 2 □ Feta		3 □Ecto	ic preg	nancy					ite of delive	Day Year
	e death the atten	sici	1 ☐ Yes 2	№ No		4∏Preg 9⊟Unk		time of d	eath	5 🗌 Othe	r (speci	ify)			_			
P.0	 requires that the deben signed by the should be detached 	Physician/Medical	Part II, Other signi		ione or	entributing to	doath hi	ut not soc	ulting in t	no undorh	ing caus		on in Bart I	230	Did tobac	CO USA COR	tribute to th	ne cause of death?
ŝ	res th	þ	Part II. Other sign	mcant condi	ions co	ontributing to	Uealii Di	ut not res	ulting ar a	ie underly	ing caus	se giv	en in Faiti.	i			3 Prob	
or o	requi	ted													+			
Records,	law lasb	Completed													Was an autopsy		prior to co	psy findings availat mpletion of cause o
	The law ate has page 2	ခြ မ												1 🗆 Y	es 2		death? 1 ☐ Yes	2□ No
Vital	ician: Th certificate rector, pag	8	25. Was case refe examiner?	orred to medic		11						Tou	26. Place of Dea	th (Check o	nly one)			
of	× 5	ည		9 10			Inpatie		ER/Outp		DOA	Oth	4 Nursing n	_			ner (Specif	y)
	ing After unel	9	27. Manner of Dea 1 Natural	5 Pend		1	e of Injur onth, Day	Year)	28b. Tin Inju	ıry		. Injun		28d. Desc	ribe now i	njury occu	rrea	
Sio	Attending r death.	cat	2 Accident	inves 6 ☐ Could	tigation I not be					M			Yes 2 □No	006 1 1	on /C+	t and Mir-	has as D	J Causa Mumba
Division	2	Certification:	4 Homicide	dotor	mined	200. Plat	ce of Inju ding, etc	ury - At ho c. <i>(Specif</i>	ome, tarn y)	n, street, fa	ictory, o	ntice			r Town, S		oer or Hufa	il Route Number,
	spital or Attend nours after death neral Director: /	Ce	20a C-+4'	1 To Carrie	ine Ph	veicien: T= "	no ba	of mustic	uulode -	doath -		the c	no data and size	and di-	the a	0(0) 004	20004	totod
	Hospi 24 hour Funer Funer	edicai	29a. Certifier (Check only one)			iner: On the		examina					ne, date and place pinion, death occu					
	To the Hospital of within 24 hours at To the Funeral Completely filled it	Med	29b. Signature an	d fine of certif	ier	4114	7				29c. L	icens	e number		29d.	Date signe	ed (Month,	Day, Year)
_	F 3 F 3	Y		11	/	-	/											

State Registrar

DHMH 17 Rev 1/2001

APR 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEUNARD RICHARDSON M.D. 1838 GREENE TREE ROAD #300 PILESVILLE MD 2120 8

31. Date filed (Month, Day, Year)

APR 1 9 2007

32 Registrar's Signature

2007

APRIL 12

DS7722

			For State	State of Maryla		rtment of H			-2111111	12582
		Registrar 1. Decedent's Name (First, Middle, Last)						2 Date of Death	. Nor	3. Time of Death
	Physicia /Medic		George	McCrea	dy			Month 04	Day 08 Year	7 5:25p. M
	Examin		4a. Facility Name (If not institution, give		,	4b. City, Town, or	Location of Death		4c. County of Deat	4
			College View	CA 700 TO		Fred	erick		frederi	
	Funeral Director		5. Social Security Number 6. Se 218–26–0570	x 7. Age (<i>In yr</i> : ▼M 2□F 81	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) July 29,	1925 °0	hptace (State or Foreign untry) hio
	ס	ļ	Usual Residence of Decedent							10d. Inside City Limits
	arylar ehow	ž	10a. State 10b. County MD Anne A	rundel	City, Town or Lo	everna Pa	m1e			1 ☐ Yes 2√2 No
	death with the Maryland ims 23a or 28s-f ehow r nust be notified at	Director	10e. Street and Number	Tunder		10f. Zip Code	IK	100	. Citizen of What Co	
	Sa or		132 Idlewood Roa	d			146		USA	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
36	2 should be filed within 72 hours after death with the Marylan and Menth Hygiens. In marked other then "naturel", or litems 23a or 28s-1 show the marked other then "naturel", or litems caust be notified at sumatic event. The Martical Exeminer caust be notified at	by Fui	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 No If Yes, Give Year or Dates: 44.		Yes 2X No	Specify:	ritoari, etc.,	Specify:	white
Š	2 hou		15. Decedent's Edu	ucation	16a. Deced	lent's Usual Occupa	ation during most of work		b. Kind of Business	Industry
Maryland 21215-0036	ithin 7 ne.	Completed	(Specify only highest grad	College (1-4or 5+)	life. L	OO NOT use retired)		o 6	
2	lied w lygier her th	Cor	12 17. Father's Name (First, Middle, Last)	5+			18. Mother's Name		S foreign	service
auc	d be f) Be	George Harvey Mo	Creday Sr				rguirite		
<u></u>	d 2 should be f th and Mental P 7 is marked of treumatic eve	ဥ	19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Street a			City or Town, State,	Zip Code)
Σ			Laura Burns/daugh	ter	2408	Greyston	e Lane Fr	ederick,	MD 21702	2
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 eny injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☒ Donation 5 ☐ Other-(Specify,	Removal from State	. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date 20	oc. Location - City or	Town, State
Balti	permit. Departm Importate ony inju		21. Signature of Euneral Service Licens						Baltimore	Street
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the de	eath. Do not ent	er the mode of dyin	MD 2120 g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Card	rmon	opath	V			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		1			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Doe to (or as a cons	эqueлсе of).					
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a cons	equence of):					
687	ficate physics	edical		d.						
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
0	res that th igned by be detac	by Ph	Part II. Other significant conditions co	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	icco use contribute t	o the cause of death?
rds	w require been sig should b	ed b	Metastanic	· Psesta	14 C	ancer		1 ☐ Yes	2.2NO 3□P	robably 4 🗆 Unknown
Division of Vital Records,	Physicien: The law requiriths certificate has been ral director, page 2 should	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
<u>ita</u>	Physicien: r this certifica ral director, p	BeC	25. Was case referred to medical examiner?					h (Check only one)	
<u>5</u>	hysic this co	ဥ	1 ☐ Yes 2 ☐ No		☐ ER/Outpatier		4 Nursing Ho		ce 6 Other (Spe	ecify)
5	ding F	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)) 28b. Time of Injury	Wor	y at k? Yes 2 □No	28d. Describe hov	njury occurred	
<u>isi</u>	Attending or death. ector: Alter by the fune	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	t home, farm, str				et and Number or R	ural Route Number,
á	tal or A rs after al Direc ed in by	Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Town,	Siale)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ysician: To the best of my kiner: On the basis of examand manner stated.						
	To the within 2. To the P	¥.	29b. Signalule and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
			1000	· WIS	100 000 00		60417		1/11/07	
			30. Name and address of person who of Heme Shill in	completed cause of death (F	Thoma	<u>1</u>	nsan by	Fred	enicic	MD 21702
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nnatura					
	Regist	al	APR 1 9 200	1 ARMINES A	to Allah	Car				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1:30 OLM ALFONSO MILLA 07 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner Baltimore Green Center ong If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 M 2□ F 219-56-445 77 AUGUST 2, 1929 Peru Director Usual Residence of Oecedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4225 York Rd 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Hispanic Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chauffeur Self-employed nd 2 should be fited vilth and Mental Hygie 27 is marked other if treumatic sysnt, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dionicio Milla Sebastinia Carrion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Heelth ar Important: If Itsm 27 is sny injury or other treu once. / SPOUSE 150 Sellers Avenue Co MGE-3V2 Toronto Ontario Canada Sotela Milla Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry April 18, 2007 Hanover, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive suite P. Hanover, My 21076 150 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage End **Physician** /Medical Due to (or as a consequence of): Examiner Ence Henritic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner palbampenus physicien and s the burial-transit Due to (dr as a consequence of): Be Completed by Physician/Medical ate hes been signed by the ettending physpage 2 should be detached for use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Oate of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy himic 1 Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or A within 24 hours effer To the Funeral Direct completely filled in by 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00064788 MD 16 0 who completed cause of death (Item 23a) (Type, Print) ROYAL AUE BALTIMORE Sharma 1600 W. Mt. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year **Physician** April 16, 6:40A MARY ELIZABETH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2XX Months Days Hours 212-28-5493 77 February 19,1930 Director Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Fairfax Clifton Virginia altimore, Maryland 21215-0036 0640 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20124 USA 13912 Springhouse Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes XIX No þ Specify. 3XXWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental William Lawrence Blocher Ellinor Elizabeth Smyrk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Harry L Myers 13912 Springhouse Court Clifton Virginia 20124 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Pleasant Grove ChCem: 4/20/07 Reisterstown, Maryland A ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer Disease 1 Cars incivila /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. <u>Ş</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Division or Vital 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSPILE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural (Month, Day Year) Injury 5 Pending 1 Yes 2 No ours after death.

neral Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 🚾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Ch CHARLES. S an visino 31. Date filed (Month, Day, Year) 32. Registrar's Signature Blaues & Sparks ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11222 H M **Physician** John Martin Jr. Η. 17,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Burnit Machin Windhim Soltimora Hours Min. 8. Date of Birth (Month, Day, NOV 19 If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** West Virginia Months Days 1 XM 2 ☐ F 73 Director 218-28-4716 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 🕅 No Director Maryland Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or edical Examiner must be 7959 Telegraph Road Lot 7 21144 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: white Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Printer news paper printing permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other ti any injury or other traumatic event, the 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Sr. John Η. Louise Custer မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. Westminster MD 20c. Location - City or Town, State 21158 1148 Hembent School House Michael W W. Martin _Rd_ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cem 4/23/07 Crownsville MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Immediate Cause (Final disease or condition resulting in death) (ancer **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 (No Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 hpatient Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury i ⊟ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 0 Grifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29d. Date signed (Month, Day, Year) d title of certi 29b. Signature a empleted cause of death (Item 23a) (Type, Print) 30. Name and address of persor +1 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

とろうが

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April **Physician** 18, 2007 Marie M. Nixon 4:00a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ivy Hall Middle River Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 ₩ F Months Hours June Maryland 87 Director 214-14-1937 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Baltimore Middle River Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 9 Mira Court 21220 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items clical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Levinson Klein Co. Personal Secretary 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Ditzel George Weidinger Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Mira Court Baltimore MD 21220 Peggy Carr 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore Cemetery N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signatur V Funer J Some Licer see Balto Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate
Interval Between
Onset and Death
Um - Charm Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No ģ Month Year Day 4☐Pregnant at time of death as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performed?
1□ Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ASSITE 17 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident filled in by the I 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral Completely filled it To the Hospital l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-19-2007. M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASERM. 709. EASTBRN BLVD -MO -21221

State

Registrar

31. Date filed (Month, Day, Year) APR 1 9 2007

WASBRM 32. Registrar's Signature

		For State Registrar	State of Ma	aryland				lealth an Death	d Mental I	Hygien Reg. N	$Z \coprod I$	7	12587
Physicia /Medic		1. Decedent's Name (First, Middle William Jacks	on Nolker						2. Date of Month 64	Death	ay	Year	3. Time of Death 5:05 AX
Examine	er	4a. Facility Name (If not institution FRANKIIN SQ. 5. Social Security Number	upre Has	pital e (In yrs. Ia	st hirthday)	4b. City,	Sed	Location of D		P	SAL	of Death	ore
Funeral Director		216-05-1581 Usual Residence of Decedent	1 X O 4 M 2□ F	93	Yrs.	Months	Days		Apri Apri	Day, Year	13	Mary	place (State or Foreign ntry) land
ie Marylan 8e-f show	ctor	MD Baltin	nore		Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
dath with th	Funeral Director	10e. Street and Number 2019 Wintergree	n Place			10f. Zip	Code 237			_	itizen of S.A	What Cou	ntry?
033 (ms a	2	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? ied 1 X Yes 2 □ N If Yes, Give Year or Dates: W	lo		Was Deced f Yes, sped 1 ☐ Yes		spanic Origin' n, Mexican, Pi Specify:	? (Specify Yes or uerto Rican, etc.)	No-	Bla	ce - Americk, White,	
re, Maryland 21215-0 re, Maryland 21215-0 s 1 end 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, the Madical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 5-	+)	16a. Deced (Give life. L Firef	kind of wo DO NOT us	rk done d se retired	furing most of	working			re Ç	Fire
yland yland ould be file I Mental Hy sattle event	To Be	17. Father's Name (First, Middle, I John Henry Nolk	er					Mary E	Name (First, Mio Etta Kra	ft			
Baltimore, Maryland 21 permit. Pages 1 end 2 should be flied will Department of Health and Mental Hygien Importent: If tlem 27 is marked other th any injury or other traumatic event, the		19a. Informant's Name/Relationsh Patricia Meisel 20a. Method of Disposition	/ Daughter	20b. Pla		Winte	ergre	een Pla	Rural Route Nu ICE Balt Date	imore	, MD	2123	
Baltime Bartime Department Page Department In In In In In In In In In In In In In		1XX Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service)	pecify)		`kwood	Ceme	etery d Addres		.9/2007	Par altim 305 H			Maryland 21214
876(ate be hysicia the bur	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. //CARC Due to (or as a b. Due to (or as a c. Due to (or as a d.	a conseque	nce of):	Ha	ברחו	`a_					Initerval Between Onset and Death
Box 6 Bath certific ettending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 🗌 Fetal d	eath 3□	Ectopic pro						te of delive	ery Day Year
rds, P quires that n signed b	a by Pr	Part II. Other significant condition Congestive				derlying ca	ause give	n in Part I.		_	use cont		ne cause of death?
	e completed by	Renal failui	12						pe 1□ Ye	itopsy erformed? s 2 No		prior to cor death?	psy findings available mpletion of cause of
of Vita Physician: rthis certifica	0	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Inpatien 28a. Date of Injury		NOutpatient		A Othe	r: 4 ☐ Nursin	Death (Check on g Home 5 ☐ R	esidence			v)
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral director.	Lincation	1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could not determine	(Month, Day	Year) ry - At home	Injury	М		at ? ′es 2 ∐No	28d. Describ	n (Street ar	nd Numb		al Route Number,
Di lospital or hours aft uneral Di by filled in		29a. Certifier Certifying			edge, death	occurred a	at the time	e, date and pla		Town, State		inner as st	ated.
To the Hosp within 24 hou To the Funei completely fill	200	one) 29b. Signature and title of certifler.	Physician: To the best of examiner: On the basis of and manner state and manner state who completed cause of dea 9000 Factor 32. Registrar	ed.	T and of the	290.	License	number	d<4	29d. Da	te signe	d (Month, I	Day, Year)
10 x1		30. Name and addre of person w	nho completed cause of dea 9000 Fakir	ath (Item 2:	3a) (Type, F	Print)	RI	Hanne	WD	2 123	2	. 0, 0	
State Registrar		31. Date filed (Month, Day, Year) APR 1	3 2007 32. Registrar	r's Signatur	M. A	Joseph .		.,			12.73		and a second

10 X /

DHMH 17 Rev 1/2001

State Registrar ENTER

JOBINDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HOS BITAL

32. Registrar's Signature

APRIL 16

			1 - For State Registrar	State of Maryland		artment			ind Me		200	7 12590
	Physic		1. Decedent's Name (First, Middle, Last	•					2	2 Date of Dea Month	Day Ye	3. Time of Death
	/Medi Exami		TANE FRAN 4a. Facility Name (If not institution, give	street and number)	2010	4b. City, T	Town, or L	ocation o		04	4c. County of C	Death
	Funeral Director		5. Social Security Number 6. Se	TOSPITAL 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	e Maryland Se-f show	ctor	Usual Residence of Decedent 10a. State 10b. County PC (6)		, Town or Lo							10d. Inside City Limits 1
	ath with the 23s or 21	Funeral Director		ACHE TEAR			07				log. Citizen of Wha	t Country?
036	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23a or 28e-f show he Medical Examinat rivest be notified at	è	11. Marital Atatus 1 Never Married 2 Narried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decede fYes, speci I ☐ Yes 2	. /	panic Orig Mexican, Specify:	rin? (Speci Puerto Ri	fy Yes or No- can, etc.)	Black, V	American Indian, White, etc. 3 LACK
21215-0036	within 72 ho iene. rthen "netu the Wedical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) NONE	cation e completed) College (1-4or 5+)	life. L	lent's Usual kind of work DO NOT use	done du	ion ring most	of working		16b. Kind of Busine	ess/industry
Maryland 2	2 should be filed and Mental Hygis Is marked other eumatic event, II	To Be C	17. Father's Name (First, Middle, Last)			попе			's Name (none Maiden Sumame) WACH	uku
Baltimore, Mary	Health tem 27 other tr		19a. Informant's Name/Relationship (7) LOCA CIROSS T 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	HOSPITAL 20b. Pla demoval from State	19b. Mailin	FOR sition (Name	RST of			Route Number	, City or Town, Sta	re, Zip Code) RNUG MD 20910
Baltii	permit. Pages Department of Important: If I eny Injury or one		21. Signature of Funeral Service Licens	in state Nie Director		Name and tate altim			3 3 2120		. Baltimo	re Street
À	Physician /Medical Examiner		25a. Part Enter the disease, or complishock or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	cations that caused the death. the cause on each line. EXTREM Due to (or as a consequence)	L PR	er the mode		_	ardiac or r	espiratory arr	est,	Approximate Interval Between Onset and Death 24 WEEKS
8760,	rate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to consequence). Due to (or as a consequence).	ence of):	NE	NB	RA	N.P.			
Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□	Ectopic pred					23d. Date of Month	delivery Day Year
ords, P	law requires that the as been signed by th 2 should be detache	ted by P	Part II. Other significant conditions con			derlying cau	use given	in Part I.				e to the cause of death?] Probably 4 □Unknown
r	The ate h page	Completed by								24a. Was a autops perform	24b. Were prior death	
ō	ling Phys n. After this funeral dir	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		R/Outpatient 28b. Time of Injury		Other: c. Injury at Work?	4 🗆 Nurs	sing Home		ence 6 Other (Sow injury occurred	Specify)
=	5 th 5 c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)						City or Town	i, State)	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	ician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in	n my opin	ion, death	place, and occurred	at the time, da	ate and place, and	due to the cause(s)
	T wit		29b. Signature and title of certifier	MC		D	License n	umber		24	OH / 12	onth, Day, Year)
	Sta	te	30. Name and address of person who co MAN 317 RIS 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 2 MM MD 3 32. Registrar's Signatu	000		HEL	LVU	LLE	2D Ba	DWIE MI	0 20716
	Registr	_	APP 1 0	onny Pagasa	M. A.	many.	8					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 2007 April 18, Leah Parker I. 9:45a м 4a. Facility Name (If not institution, give street and number) Harmony Hall Assisted Living 4c. County of Death Howard Town, or Location of Death Columbia If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number 201–12–1995 1 M 200 82 2/25/1925 PA 10c. City, Town or Location 10d. Inside Cify Limits 10b. County

Director Usual Residence of Decedent the Maryland 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Ellicott City MD Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 10400 Boca Raton Drive Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 Yes, Give 2 **X**No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 Divorced Year or Dates: er than "natur, the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than other traumatic event, the M Operations Officer 12 17. Father's Name (First, Middle, Last, Richard Parcell 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10400 Boca Raton Drive, Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type. Print) Amy L. Hundley / Daughter permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harleigh Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖫 Removal from State April 23, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. Mars 1501 East Fort Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes page 2 should 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) 3□ DOA 1 Yes 2 XNo 2 ER/Outpatient မ After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 🔼 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Assisted living

18,2001

21230

Approximate Interval Betweer Onset and Death

8 mouths

1 No 2 No

14. Race - American Indian,

White

Black, White, etc.

Bank

Camden, NJ

Month

2□ No

Registrar

Physician

/Medical

Examiner

Funeral

APR 1 9 2007

8

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



AB

State DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) hysician/ 2. Date of Death 3. Time of Death Month Day April 17, 2007 Paul xaminer Petrick 0223 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 217-50-3386 Director Months Days Hours 1 X M 2 F 59 October 8,1947 Country) MD. Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Baltimore 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1648 Frenchs Avenue 21221 USA uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? Never Married Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes ũ 3 Widowed 4 XDivorced If Yes, Give Year Yes 2 X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 the Medica 12 years 2 years Project Manager Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Joseph Petrick other traumatic event, Margaret Anna Krebs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcy Petrick Daughter 11 Terrace Road Es<u>sex</u> MD20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) April 19, 20c. Location - City or Town, State Bayview Crematory 1 Burial 2 X Cremation 3 Removal from State 2007 Baltimore, MD. Donation 5 Other Specify. 21 Signature of Foheral Service Licensee Confidency Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 'sician Approximate Interval failure. List only one cause on each line. edical، Between Onset and Cirrhosis of the liver Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Alcohol abuse Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical the attending physician of for use as the burial X UNPENDED 4#252ED, 27, perME, g867, 5/10/07 TT Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 3 Ectopic pregnancy past 12 months? Fetal death Day Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other₄ Inpatient 2 ✓ ER/Outpatient 3 DOA 1 V Yes Nursing Home 5 Residence 6 Other: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospins... within 24 hours after death.

To the Funeral Director: A' 1 X Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 17, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

31. Date filed (Month, Day, Year)

APR 1

ORIGINAL

32 Registrar's Signature

07-029	58
Robert	Fra

7-02958 obert Francis R			i Indelible epartment (C <i>ertificate</i> (of Health a	ire All Co and Menta	opies Ar al Hygier	ic .	21	07 1259
Physicia	Re	gistrar Decedent's Name (First, Middle,Last) Robert Mannin	g Rumney,			2. Date Mor	Reg. No e of Death oth Day il 17, 2007		3. Time of Death 2017 hrs
Meg' 'Examir	ner	Robert Rum a. Facility Name (if not institution, give street and number) 316 S. Calhoun Street	ney	4b. City, Town		Death		tc. County of De	A
Funeral Director	5		yrs. last birthday)	If Under 1 Months I			ate of Birth (MI 9/28/19	1FC	Birthplace (State or or or or or or or or or or or or or
d o now any	1	sual Residence of Decedent Oa. State 10b. County 10c. Maryland N/A	. City, Town or Lo Baltime						10d. Inside City Limits 1 X Yes 2 No
the Marylan a or 28a-f s'	Director	Oe. Street and Number 316 S. Calhoun Street			223	10/0 ::(1)		U.S.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1. Marital Status 1. Never Married 2. Married Armed Forces? 1. Yes 2. X Widowed 4. Divorced If Yes, Give Year or Dates:	No 1	Was Decedent of If Yes, specify C Yes 2 X edent's Usual Occ	No specify:	Puerto Rican	, etc.)	White, e	White
136 hin 72 hours : e. than "natur: edical Exami	ompleted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) 12th	durin	warehous	g life. DO NOT eman	use retired)	ļ		t Distillery
1215-00 I be filed wit ental Hygien arked other	Be Con	17. Father's Name (First, Middle, Last) Robert M. Rumne 19a. Informant's Name/Relationship (Type, Print)	ey Sr.	ailing Address		August	a Heal	r, City or Town,	State, Zip Code)
re, MD 27 11 and 2 should F Health and M f item 27 is m er traumatic e	1	Nannette Meyers / sister 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State	325 20b. Place of Di	o - 10th	Avenue of cemetery,	Ba	1timore	oc. Location - C	land 21225 Sity or Town, State ge, Maryland
Baltimol permit. Pages Department of Important: I		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Headow	22. Name and Ad	tchie I	y Gond	e Fune	ral Ser	vice, P.A. Marvland 2122
nhysician edical aminer		26a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	.s	nter the mode of	dying, such as		phatory uncon	, 5.150.1,	Between Onset an Death
ed 200	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):						
68760, certificate be executed nding physician and see as the burial - transit	ज	IF FEMALE: 23b. Was decedent pregnant in the	BI, perME, a-f, perME e of pregnancy	g868, 6/2 , g868, 6/		pic pregnancy		23d. Date of Month	delivery Day Year
Box 687 e death certifi the attending	Physician/Medic	past 12 months? 1 Yes 2 No 9 Unknown g Unknown		Other (Spec		Parti	23e. Did tob	acco use contri	bute to the cause of death?
P.O.	ted by PI	Part II. Other significant conditions contributing to death	but not resulting i	n the underlying				2 No 3	Probably 4 V Unknown Were autopsy findings availal prior to completion of cause of
Record: The law re- ifficate has be	Completed	25. Was case referred to medical		2	26.Place of Dea		perform 1 Yes 2 y one)	ned? (death? Yes 2 No
n of Vital Recing Physician: The	neral director, page	examiner? 1 Ves 2 No Hospital: 1 Inpatier 27 Mapper of Death 28a. Date of Injur			OA Other 428c. Injury at W	ork? 28		ow injury occur	Other: Scene
Division of Vital Records, sopial or Attending Physician: The law require hours after death.	Certification: T	1 Natural 5 Pending Fnd 4/17/2 2 X Accident Investigation 28e. Place of Inj 3 Suicide 6 Could not be determined (Specify) real	ury - At home, far sidence		, office building	, etc. 2	or Town, S	street and Numb tate) 316 S ahour St	per or Rural Route Number, C . Calhoun St. . Baltimore, MD
<u>i.</u> g <u>i.</u>	completely fille			vestigation, in m	e time, date and y opinion, deatl c. License num	place, and do	o to the caus	e(s) and manne and place, and	er as stated.
O FIRE	S M	The day of the Try	un).		O.C.M.E.			April 18, 2	
10 Bar		32 Registra	leath (Item 23a) ledical Exami	4	enn Street,	Baltimore,	MD 2120	1	
Reg	Stat gistra	e St. Date mod (Month, Day) . Cary	300 B	front.	/				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Ruth Elizabeth Rupe 11:30 AM April 17 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1307 Saunders Way Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔀 F June 26, 1922 022 18 1420 84 Massachusetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 👿 No Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e and any injury or other traumatic event. The Mandal Conce. 1307 Saunders Way U.S.A. 21061 Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) Antique Dealer Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter F. Inglesby Francis R.H. Bennett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 1307 Saunders Way Joyce Pinion / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 4/19/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. nway Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as 1 or nsequence by Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 13 No 9 Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death. neral Director: After this or filled in by the funeral dire 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

17

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date (ied (Month, Day,

MA

Year,

Medical

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March March 2007 Phyllis Lucille Ritter 7:10 рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner avale Allega Braddoc KOAO If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day,) ocial Security Number 6. Sex yrs. last birthday Birthplace Country) State or Foreign **Funeral** 215-16-481 Months 1 □ M 2 F Yrs Director JURANTSUILLE MD Usual Residence of Decedent death with the Maryland City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow any Injury or other traumatic event, the Medical Experiment must be notified at once. 10a. State 10b. County 1 Yes 2 No Funeral Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code lock Koad 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No þ Specify. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurses aldE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be)OrMAN 19a, Informant's Name/Relationship (Type, Print) density or Town, State, Zip Code) 2/502 ddock in-law 1121 Jule 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Stale 4 Donation 5 Other (Specify) ltimore 21. Signature of Euneral Servi Name and Address of Facility State Anatomy 22. Name and mector Board 655 W. Baltimore Street 21201 m Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 ☐ Yes 25 No Completed 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2€ No 24a. Was an certificete has 1 ☐ Yes 22110 To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0054411 BEVERLY on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of/per 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State 2846 APR 19 2007 Registrar

			1 - For State Registrar	State of Marylan		artment of H rtificate of			Reg. No.	007	12597
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		ARKADIY			RATSIMOR		APRIL	16	2007 ounty of Death	
	Examin	er	4a. Facility Name (If not institution, give				r Location of Deat	n		BALTIM	
			JEWISH CONVALES 5. Social Security Number 6. S		last birthday	BALTIM If Under 1 Year		8. Date of Birt			place (State or Foreign intry)
	Funeral Director			XIM 2□F 91	Yrs.	Months Days	Hours Min.	01/08/1	v, Year) 916	Cou	RUSSIA
	311 COLO1		Usual Residence of Decedent					1027 007 2			
rylan	how	_	10a. State 10b. County		y, Town or Li						10d. Inside City Limits 1 ☐ Yes 2 No
е Ма	Sa-fs	cto	MD BALT	IMORE E	BALTIM						
ith th	or 2	Funeral Director	10e. Street and Number	DOAD		10f. Zip Code	.0			n of What Cou	intry?
ath w	s 23a	ra	7920 SCOTTS LEVEL	RUAU 12. Was Decedent Ever in U.	S 13	Was Decedent of h		Specify Yes or No		USA Race - Amer	ican Indian,
ler de	Hem	Ę	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?		Was Decedent of H If Yes, specify Cub		to Rican, etc.)		Black, White	, etc.
urs af	o le	by	3 ♥ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2XX No	Specify:		Sp	pecify: WH	ITE
U K I K I 3-0030 filed within 72 hours after death with the Maryland	I Hygiene. other then "naturel", or items 23s or 28s-1 show vent, the Medical Examination must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation during most of wo	rking	16b. Kind	of Business/l	ndustry
thin 7	. Mari	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d)			TEDTAT	NIA C NT
- N P@	ygien t. En	S	12		IEC	HNICIAN	10 Mathara Na	me (First, Middle,		TERTAI	NMENI
	ental Hygiene. ked other ther ic event, the	Be	17. Father's Name (First, Middle, Last, MOSHE		RATSI	MUB	FRIED		Walder Sc		NOWN
_ =	nd Menta marked matic ev	2	19a. Informant's Name/Relationship (Type Print)		ing Address (Street			r. City or T		
Q 2	th ar 7 is treu			ON	1	OLD PIML					209
1 and	Health tem 27		20a. Method of Disposition	20b. F	lace of Disp	osition (Name of		Date		tion - City or T	Town, State
Pages	ant of ht: If i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State AF	ZUK AI	ON°CEMETE MUNO	TRY 04/1	8/2007	RAI TI	MORE,	MD
i i	Department of Heal Importent: If item 2 any Injury or other once.		21. Signature of Funeral Service Licer	10112		2. Name and Addre		OL LEVIN		_	
ă	Depa Impo any Ir		Statt M-	auth		8900 REIS	TERSTOWN	ROAD -	PIKES		MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rest,		Approximate Interval Between Onset and Death
Pr	ysician		Immediate Cause (Final disease or condition	. Failur	e t	o thr	ive	-			3 months
	Medical kaminer		resulting in death)	Due to (or as a conseq		4.1					> 6 months
	Kaiiiiiei	_	Sequentially list conditions,	b. Endstag Due to (or as a conse		ementia					כוערות טוחיים ל
pe	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice or).						
хөсп	al-trai	xan	that initiated events resulting in death) Last	C Due to (or as a conseq	uence of):						
ECOLUS, P.O. BOX 66/60, law requires that the death certificate be executed	ohysician and the burial-transit	lical		d							
Oo	g phys as the										
y Series	been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Feta		⊒Ectopic pregnanc	v		230	d. Date of deli Month	very Day Year
deat	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐Unknown		Other (specify)	<u> </u>			WOITH	Day run
at the	d by the	Ph.	9 Unknown		ultina in the		une in Bort I	23e Did t	nhacco use	contribute to	the cause of death?
es the	ignec be d	by	Part II. Other significant conditions of the Pebrovas						Yes 2□		
law requires 1	hould	eted	_ cerebro vasa	Mai accien	2111	DYSPINA	0				topsy findings available
e aw	has b	Completed						24a. Was autor perfo	osv	prior to death?	ompletion of cause of
1 =	icate r, pag								rmed? 2 No	1 🗆 Yes	2 □ No
VII AII	certif	Be	25. Was case referred to medical examiner?	Hospital:	FD/0	-1 20 DOA Ot	Law	eath (Check only only only only only only only only		Other (Spec	264
2 g	rthis raldi	- T	1 Yes 2 No	28a. Date of Injury	ER/Outpatie			28d. Describe			-1197
	th. : Afte	tlor	1 Natural 5 ☐ Pending investigatio	(Month, Day Year)	Injury		rk?]Yes 2∐No				
IVISION r Attending	ector by the	Certification;	3 Suicide 6 Could not be determined		ome, farm, si	treet, factory, office		28f. Location (: City or To	Street and I	Number or Ru	ral Route Number,
2 5	of in B	Sert	4 Homede	building, etc. (Special	y)						
ospil	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier 1 Certifying PI	nysicien: To the best of my kno miner: On the basis of examina	owledge, dea	th occurred at the ti	ime, date and plac	e, and due to the turred at the time,	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
the H	the F	Medical	опе)	and manner stated.		29c. Licen				signed (Month	
5	To con	2	29b. Signature and title of certifier	egun. MD			5 3 9 2	.8		117/2	
			1		- 02-1 7	Print) (+ 10A	1144 (2)	EGUM		1 1 / / "	,
			30. Name and address of person who 2434 W, BE	LVEDERE /	1 23a) (1ype 4ve	BALTIMA	RF . MN	-2121	5		
	Ste	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Signa	ature		1110				
	Renist		ADD 1 O	2007	R	Sugar 1					

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Nertificate of Death		iene () 7	12598
			Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
	Physici		JAMES MELVIN ROBERTSON		April	13, 2007	4:00PM M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	, ,,p, <u>, , , , , , , , , , , , , , , , </u>	4c. County of Deat	
1	:		Manor Care Ruxton	Towson		Baltim	ore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, April 2	Year) 9. Birt	hplace (State or Foreign
	Director		224-18-0827 XX M 2 F 86 Yrs.	Working Day's Flours Will.	April 2	, 1921 Vi	rginia
	pug *		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation			10d. Inside City Limits
	show	2		DOL(IO)			1 Tyes 2 No
	the Market 288-f	ect	Maryland Baltimore Towson 10e. Street and Number	10f. Zip Code	10	og, Citizen of What Co	
	with o	Ö	1034 Kennilworth Drive	21204		USA	unay.
	leath	era			ecify Yes or No-	14. Race - Ame	erican Indian,
(0	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If items 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic avent, the Medical Exertions in until be invitible at	Funeral Director	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No WWII	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
03	al', o	by	3 XVidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes X2X☐ No Specify:		Specify:	White
21215-0036	72 ho	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation s kind of work done during most of work	cina 1	16b. Kind of Business/	Industry
2	within ene. than "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9		
	filed w Hygier Ather th	S		iter Operator	/mi	Railroad	
and and	be fill	Be	17. Father's Name (First, Middle, Last) Herbert Russell Robertson	Lucy May	e (First, Middle, N	faiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic avent, to Ma	2		ing Address (Street and Number or Rur		City or Town State	Zin Cada)
Ma	d 2 sl th an 7 Isr		1121	Kennilworth Drive			
100	other tr		20a Method of Disposition 20b. Place of Disp	osition (Name of	-	20c. Location - City or	
20	Pages nent of I int: If it		XXBurial 2 □ Cremation 3 XXemoval from State cemetery, cre	omatory or other place)	7/07 S	iteele's Tave	m Virginia
Baltimore,				2. Name and Address of Facility Mit			
Ba	permit. Departr importa any inju		X Bunis (Deaker (Kena Des)			re, Maryland	
	STREET		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only a re cause on each line.			THE RESIDENCE OF THE PARTY OF T	Approximate Interval Between
	Physician		Immediate Cause (Final	= ROTIC CAR DIC	NASCUL	AR DISAM	Onset and Death
7	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	100110011	70.0000	المنافية المنافية	- gras
п	Examiner		D. D. D. D. D. D. D. D. D. D. D. D. D. D				O
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
$\sqrt{}$	ocuted nd trans	Examiner	that minated events				
, 00	ate be executed bhysician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d				
9	leath certific attending p I for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	attend for us	Physician/Me	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown 9 Unknown	_ Other (specify)			
<u>α</u>	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires n sigr ild be	d b	Ischemic cardionyapathe		1	s 2 No 3 Pr	obably 4 Unknown
00	w requir been si should	lete			24a. Was ar	24b. Were au	topsy findings available
Re	he lav e has age 2	Completed by		J	autops; perfore	y prior to o	completion of cause of
Vital Records,	icien: Th certificate ector, pag	a)	25. Was case referred to medical	26 Place of Deal	1 ☐ Yes 2		2 No
>	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor \ A		nce 6 □Other (Spe	cifv)
10	ding Phys n. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time	- /-		w injury occurred	,
ior	Attendin death. ctor: Afr y the fur	atlo	2 Accident investigation	M 1 Yes 2 No			
Division of	l or Attendater death Diractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	reet, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	ital o						
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only (C	th occurred at the time, date and place, avestigation, in my opinion, death occur	and due to the ca red at the time, da	iuse(s) and manner as ite and place, and due	stated. to the cause(s)
	thin 2 the the mplel	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Monti	h. Dav. Year)
	8 7 8 7						3mm 7
	~		30. Name and address of person who completed cause of death (Item 23a) (Type	Print		1000	, ,
	8		Pudano R Paul Vuerno 1650	05N. Charles St S	verter 20	R/Basto	ND 2130X
	Sta	ate	31. Date filed (Month, Day, Year)	N. J.		1	
•	Regist	rar	APR 1 9 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 Month Physician Betty G. Rohrback /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Examiner RNIE if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🔀 F 215-28-6846 Director 04 76 Nov. 1930 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2√ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 618 New Jersey Avenue 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White <u>^</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chilcote Raymond L. Inez Μ. Edwards ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Chilcote 349 Grovethorn Road, Middle River, MD 21220 (brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 20 2007 1 → Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasădena, MD 21122 23a. Pa. 1. Enter the disease, 'r com, lications that cause' 17e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Conn **Physician** /Medical Due to (or as a co of quence of): Examiner Sequentially list conditions it any, leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a nonsecuence offi Examiner requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an certificate has 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

2007

V

32. Registrar's Signature

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margaret Russell April L. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilcrest Hospice Baltimore Year | If Under 24 Hrs. If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 XF Yrs. 92 Feb. 217-22-1028 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 906 Nabbs Creek Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 18. Mother's Name (Firs 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Agnes Thomas F. B. Russell 19b. Mailing Address (Street and Number or Rural Rou 19a. Informant's Name/Relationship (Type. Print) 906 Nabbs Creek Road, Gl Marvdel J. Russell Department of Healt Important: If Item 2: any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Glen Haven Cemetery 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Furriral Service Lice Stal 3111 Mountain Road, tions that caused the death. Do not enter the mode of dying, such as cardiac or res 23a. Part1. Enter the disease, or complications that cause shock, or heart failule. List only one cause on each CHOKE Immediate Cause (Final 40 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by peen page 2 has certificate 25. Was case referred to medical 26. Place of Death Ch Be Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1- Natural 5 Pending investigation s after dea... rai Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 9 2007

☐ 2☐ Married	If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 N	1 ☐ Yes 2 ☑ No Specify:			specify: White				
5. Decedent's Ed	ucation	16a. Decedent's Usual Occ	16a. Decedent's Usual Occupation			Industry				
only highest gra dary (0-12)	College (1-4or 5+)	(Give kind of work do	ng	ore City Schools						
	4	Teache		/First Middle Maide		3010013				
irst, Middle, Last)				(First, Middle, Maide						
. B. Rus	sell	1	Agnes	I. Aymo						
ne/Relationship (7 Russel		19b. Mailing Address (Stre								
sition	20b. P	lace of Disposition (Name of emetery, crematory or other)	place) Aprif	Date 20 20c.	Location - City or	Town, State				
Cremation 3 ∐ ☐ Other (<i>Specif</i>)	Hemoval from State	en Haven Cemet			n Burnie	e, Maryland				
ral Service Licer	2	22. Name and Ad	dress of Facility Stountain Roa	callings Fu	uneralHo	me, P.A.				
0.	27				ια, ιτυ Ζ	Approximate				
disease, or com failule. List only	plications that caused the death one cause on each line.	n. Do not enter the mode of	dying, such as cardiac i	or respiratory arrest,		Interval Between Onset and Death				
nai	ACU	te stro	Ke			dAYS				
	Due to (or as a consequ	uence of):								
tions.	b									
ediate	Due to (or as a consequ	uence of):								
urý	C									
	Due to (or as a consequ	uence of):								
	d									
onths?	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic pregna			23d. Date of de Month	elivery Day Year				
onths?	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 ☐ Ectopic pregna eath 5 ☐ Other (specify	/)	23e Did tohacc	Month	Day Year				
onths? No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 ☐ Ectopic pregnate ath 5 ☐ Other (specify alternating in the underlying cause	given in Part I.		Month o use contribute t	Day Year o the cause of death?				
onths? No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Sctopic pregnt seath 5 Other (specify sulting in the underlying cause	given in Part I.	1 ☐ Yes	Month o use contribute t 2 ☑ 10 3 ☐ F 24b. Were a	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of				
nths?	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not rest	I death 3 Sctopic pregnt seath 5 Other (specify sulting in the underlying cause	given in Part I.	1 ☐ Yes 24a. Was an	Month o use contribute t 2 No 3 F 24b. Were a prior to death?	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of				
nt conditions of	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not rest	I death 3 Sctopic pregnt seath 5 Other (specify sulting in the underlying cause	given in Part I.	1 ☐ Yes 24a. Was an autopsy performed3	Month o use contribute t 2 No 3 F 24b. Were a prior to death?	o the cause of death? robably 4 Unknown utopsy findings available				
int conditions of	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not rest 2 M 6 2 C S M Avieny Co	I death 3 Sctopic pregnt seath 5 Other (specify ulting in the underlying cause 2 Care	e given in Part I. 26. Place of Deat	1 Yes 24a. Was an autopsy performed; 1 Yes 2	Month o use contribute t 2 No 3 P 24b. Were a prior to death? 1 Ye:	Day Year o the cause of death? robably 4 Unknown uutopsy findings available completion of cause of				
ant conditions of the medical	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not resu Aviery Hospital: 1 Inpatient 2 I 28a. Date of Injury	I death 3 Sctopic pregnie ath 5 Other (specify Ulting in the underlying cause 2 Care	26. Place of Deat Other:	1 Yes 24a. Was an autopsy performed 1 Yes 2 1	Month o use contribute to 2 10 0 3 Fe prior to death? No 1 1 Yes	Day Year of the cause of death? robably 4 Unknown uutopsy findings available completion of cause of				
ant conditions of the medical	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not resu Avery Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	I death 3 Ectopic pregnie eath 5 Other (specify utiling in the underlying cause Care	e given in Part I. 26. Place of Deat	1 Yes 24a. Was an autopsy performed of the check only one one one one one one one one one one	Month o use contribute to 2 10 0 3 Fe prior to death? No 1 1 Yes	Day Year of the cause of death? robably 4 Unknown uutopsy findings available completion of cause of				
ant conditions of the conditio	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not resu Avery Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	I death 3 Ectopic pregnie eath 5 Other (specify utiling in the underlying cause Care	26. Place of Deat Other: 4 \(\text{Nursing Ho} \) Nork? 1 \(\text{Yes} \) 2 \(\text{No} \)	1 Yes 24a. Was an autopsy performed of the check only one one one one one one one one one one	Month o use contribute to the contribute of the contribute to the contribute to the contribute of the contribute to the	Day Year o the cause of death? robably 4 Unknow utopsy findings availabl completion of cause of s 2 No				
ant conditions of the medical of the	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown contributing to death but not resu Avery Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	death 3 Ectopic pregnie	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No iice	1 Yes 24a. Was an autopsy performed; 1 Yes 2 1 h Check onl one ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street)	Month o use contribute to the	Day Year o the cause of death? robably 4 Unknow uutopsy findings available completion of cause of s 2 No ecify) A J Co				
Int conditions of the medical strength of the medical	Hospital: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year) 28e. Place of injury - At he building, etc. (Specifications)	death 3 Ectopic pregnie	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No ince	1 Yes 24a. Was an autopsy performed in Yes 2 1 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Ye	Month o use contribute to the	Day Year o the cause of death? robably 4 Unknown untopsy findings available completion of cause of s 2 No ecify) H 2 1 CC aural Route Number, as stated. ue to the cause(s)				
ant conditions of the medical of the	Hospital: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year) 28e. Place of injury - At he building, etc. (Specifications)	death 3 Ectopic pregnie	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No ince	1 Yes 24a. Was an autopsy performed in Yes 2 1 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Ye	Month o use contribute to the	Day Year of the cause of death? robably 4 Unknown untopsy findings available completion of cause of secify) ecify) Gural Route Number, as stated. ue to the cause(s)				
ant conditions of the conditio	Hospital: 1 Inpatient 2 Ba. Place of Injury (Month, Day Year) 28e. Place of Injury (Month, Day Section: To the best of my knominer: On the basis of examina and manner stated.	death 3 Ectopic pregnie	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No ince	1 Yes 24a. Was an autopsy performed in Yes 2 1 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Ye	Month o use contribute to the	Day Year o the cause of death? robably 4 Unknown untopsy findings available completion of cause of s 2 No ecify) H 2 1 CC aural Route Number, as stated. ue to the cause(s)				
d to medical Pending Investigation	Hospital: 1 Inpatient 2 Reading and manner stated. 1 Investor of the best of my known of the building, etc. (Specification of the basis of examina and manner stated.	death 3 Ectopic pregneeath 5 Other (specify other specify other specific other sp	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No lice The time, date and place, my opinion, death occur	1 Yes 24a. Was an autopsy performed in Yes 2 1 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Ye	Month o use contribute to the	Day Year of the cause of death? robably 4 Unknown untopsy findings available completion of cause of secify) ecify) Gural Route Number, as stated. ue to the cause(s)				
ant conditions of the conditio	Hospital: 1 Inpatient 2 Hospital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA 28b. Time of Injury M Dome, farm, street, factory, off wild and/or investigation, in in a street of the control of the	26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No ince	1 Yes 24a. Was an autopsy performed in Yes 2 1 1 Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Ye	Month o use contribute to the	Day Year of the cause of death? robably 4 Unknown untopsy findings available completion of cause of secify) ecify) Gural Route Number, as stated. ue to the cause(s)				

2600

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 No

12:52 AM

Reg. No.

16

2007

USA

Black, White, etc.

14. Race - American Indian,

4c. County of Death

State Registrar 4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

29a. Certifier

Medical

within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last 45 **Physician** 200 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months 1 ■ M 2 🔀 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shoved and be notified at Director MD altimore 10g. Citizen of What Country? 10e. Street and Number 206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working ife. DO NOT use retired) College (1-4or 5+) is marked other Injury or other traumatic event, 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi dealth and Mental h 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/206 Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health ar Important; If item 27 is any Injury or other trau Rd Baldo-MD Apt·A· 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 20,2007 21. Signature of Funeral Service Licensee K Rd. Ra 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequ P.O. Box 68760, attending physician Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy lor Month Day in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) detached the 9☐Unknown 9 Unknown þ Part II. Other significant conditions not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Records, þ pe o 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an has autopsy perform certificate 1∐ Yes or Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes No. 2XER/Outpatient 3 DOA ဥ 1 Inpatient this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature title of o License number

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #1,4a,perMD, G866, 4/19/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Augusta J. Seibel 04 1:25 PM D8 2007 /Medical (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner Seneca Park Middle River Koad Baltemore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 E 18 Yrs. 212.26.6913 Director MD 109 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at MD Middle River 1 ☐Yes 2 No Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I 21220 Seneca. Park Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Head Cook Stharade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental I Department of Health and Mental Important: If item 27 is marked or any injury or others. Illiam Jones, or Angusta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Anundel MD Ann Kensinger Lurie Daughter 1469 Court Lowell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Mb reenmount crematory σ 21. Signature of Funeral Service Licens 22. Name and Address of augun C. Freene Funeral Sovo Facility HMORE MID 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (anc months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Box 68760. death certificate be Physician/Medical as attending asn IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year 5 Other (specify) P.O. the 9 Unknown as been signed by a 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy page ØZ No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2X100 Hospital: Other: 1 ☐ Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No death. the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Nam

31. Date filed (Month, Day,

APR 1

200

9

32. Registrar's Signature

			For State Registrar	State of N	naryiano		tificat			ario iv		giene Reg. No. 2	107	12503	
	Physici /Medic		Decedent's Name (First, Middle, Las Ma	ry P. Sei	cio						2. Date of Dea Month April	Day	Year 2007	3. Time of Death 10:50 P.M.	
	Examin		4a. Facility Name (If not institution, give		r)		_	Town, or ento	Location on	of Death			nty of Death aroli		
	Funeral Director		219 10 3300	ex 7. A	Age (In yrs. la 87	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan. 22	, Yea <i>r</i>) 1920	9. Birth Cou Mar	place (State or Foreign ntry) yland	
ite; INIAI VIAILU Z IZ IS DOUGO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carol:	ine		Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the	Funeral Director	10e. Street and Number 1901 Blue Heron Drive				10f. Zip	Code 216	529				g. Citizen of What Country? U.S.A.		
020	urs after deat al", or items ? Examiner mu		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:				Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:					В	14. Race - American Indian, Black, White, etc. Specify: White		
vithin 72 hou ne. han "natura e Medical E	Completed by					work done during most of working Fuse retired)					6b.Kind of Business/Industry State of Maryland				
/ומות	uld be filed Mental Hygi Irked other Itic event, t	To Be Co	17. Father's Name (First, Middle, Last)	ck Donlo	1						(First, Middle, ne McNe		ame)		
			19a. Informant's Name/Relationship (** Rita Hendricksc		nter	19b. Mailir 1901	-				al Route Numbe Dentor	er, City or Tow n, Mary		`	
balliiloie,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ace of Dispo metery, crei Cathe					3/2007	20c. Location	-	own, State Maryland	
Dail	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	Darie	leee	40	2. Name an	d Addres	ss of Facilities High	^{ty} Gor ghwa	nce Fune y Balt:	eral Se imore,	ervice Maryl	e, P.A. and 21225	
5 64	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	1476					or respiratory ar		7	Approximate Interval Between Onset and Death	
	cuted nd ransit	Examiner	Sequentially list conditions, if a sy, leading to this results (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events c.												
0070	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence of): d												
O. DOX 0	ding Physiclan: The law requires that the death certificate be executed 1. After this certificate has been signed by the attending physician and Inneral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal at time of de	death 3[]Ectopic pi] Other <i>(sp</i>		1				Date of delive	very Day Year	
Cords, F.	quires that is signed by uld be detai	ρ	Part II. Other significant conditions of	-		lting in the u	nderlying c	ause giv	en in Part I	l.		obacco use co /es 2 No		the cause of death?	
	The law re ate has bee page 2 sho	Completed	24a.									b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of		
	clan; ertific ictor,	Be	25. Was case referred to medical examiner?							of Deat	n (Check only o	ne)			
_	Physiclan: r this certific ral director,	ြို	1 Yes 2 No	Hospital: 1 ☐ Inpa		R/Outpatier			4 LI INL		me 5 Resid			ify)	
	Attending Pl r death. ector: After tl by the funeral	ertification:	27. Manner of Death 1 □ Hatural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		Day Year)	28b. Time o Injury	М		yat k? Yes 2□	No	28d. Describe h				
=	tal or Attend s after death al Director: , ed in by the f	Certific	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace of	njury - At hor etc. (Specify)	ne, tarm, str	eet, factor	y, office			28f. Location (S City or Tow	Street and Nui vn, State)	mber or Rui	ral Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (ysician: To the be niner: On the basis and manner	of examinati										
	within To the	ž	29b. Signature and title of certifier				290	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)	

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fer Ener 40 8129 Referre Higha

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** A PY. 1 Barbara Ann Settles 200 /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death Examiner Glen Burnie Anne Arundel Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2/4F 212 70 2893 51 Director 1, 1955 Sept. Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Glen Burnie 1 ☐ Yes 2 🙀 No Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medica Exa<u>miner must be r</u> 7976 Nolpark Court Apt. 101 U.S.A. 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John Settles Elizabeth Bennett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Michaelis / sister 646 Hallmark Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2007 Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 21. Signifium of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. way Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neu monia days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Tigury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) P.O. signed by the aid be detached f 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an has autopsy performed? Yes 2 X No page certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier du Y) J4787

Registrar

State

Madical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Lington 132. Registrar's Signature

hourtes

ter

Cen

 $\mathbf{\Sigma}$

301

60100

			For State Registrar	State of Mary		rtificate of		, ,	Jierre leg. No. 🤈 🏳	1117	12605		
	Physici	an	1. Decedent's Name (First, Middle, Last,	Sco	H			2. Date of Dea Month	th Day	Year	3. Time of Death		
}	/Medic Examin	- 0	4a. Facility Name (If not institution, give	street and number)			r Location of Death	,	4c. County	of Death			
_	.6.		MONTGOMERY 5. Social Security Number 6. Se	7 Ann //n			UEY If Under 24 Hrs.	9 Date of Birth			MERY		
	Funeral Director		404.05-1701	M 2XF 7. Age (III)	yrs. last birthday) 9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	(, Year)	Count	ace (State or Foreign THCKY		
	land ow it		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10	Od. Inside City Limits		
	Mary I-f sho fled a	ţ	MD MONTGO	DMERY 3	SILVER	Spring					1 ☐Yes 2 ☐ No		
	with the a or 28s t be noti	Funeral Director	10e. Street and Number 1513 Woodwe	ŧ		10f. Zip Code			10g. Citizen of	What Count	try?		
	death ms 23	nera	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		ce - America			
036	hin 72 hours after death with the Maryland B. an "natural", or items 23a or 23a-f show Medical Examiner must be notifled at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:		1 Yes, specify Cub	Specify:	Hican, etc.)	1	ck, White, 6 fy: 32			
5-0036	72 ho 'natur dical (eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	ı (Give	dent's Usual Occup	during most of work	ing	16b. Kind of E	Business/Ind	ustry		
77.7	d within 72 giene. er than "nal , the Medica	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		Don	n Esi	TIC		
yland	uld be file Mental Hy arked other	To Be (17. Father's Name (First, Middle, Last) HOWARD Ch	PRR			18. Mother's Nam	e (First, Middle,			,		
Mar	s 1 and 2 shou f Health and M item 27 is mai other traumai		19a. Informant's Name/Relationship (T) DEIPHINE BR	ANT	1513	BWOODU	and Number or Rui	ral Route Number	Spring.	MD	20916		
Baltimore,	(h) () 1		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	b. Place of Disponentery, cre ROWN	osition (Name of ematory or other pla Hill (EM)	(ce) 4/2	Date 2/07	20c. Location	Ilsville	= , KENTUCKY		
Balti	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service Licens	SP.CPC	2	2. Name and Addre	ess of Facility P	hillips	FUNITE	C Non	eR, (
1			23a. Part . Ent - the disease, or comp shock, or he art failure. List only of								Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	a. /U	Ti)-1		y Tract			n	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):	-							
	ينسيد	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a cor	sequence of):								
	ecutec and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cor	acoguenco of):								
68760,	rificate be executed ig physician and as the burial-transit	edical E		d							<u> </u>		
			IF FEMALE:	23c. If yes, outcome pf pr	egnancy				22d D	ate of delive	an.		
O. Box	In the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	У				Day Year		
, P.O.	w requires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions co		-	underlying cause gi	ven in Part I.	23e. Did to	obacco use cor	ntribute to th	ne cause of death?		
ords	equire en sig ould b		advan		96			1 🗆 ነ	res 26 No	3 ☐ Prob	ably 4 □Unknown		
Vital Records,	has be	Completed	renal	insuffic	ienly			24a. Was autop		. Were auto prior to cor death?	psy findings available npletion of cause of		
<u>e</u>	Physician: The la rr this certificate has rral director, page 2		25. Was case referred to medical				26. Place of Dea	1∐ Yes	2 Ø No	1 ☐ Yes	2 No		
<u> </u>	nysicia lis cert direct	To Be	examiner?	Hospital: 1 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	hor:	ome 5□ Resid		ther (Specify	y)		
0 0	Ing Pl	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury	Wo		28d. Describe	now injury occu	irred			
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	e Hospital of 24 hours at Euneral Detely filled i		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	To the h within 2- To the h complet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)		
)	r > - ō		· Ata	Motor	_ (00	06399	9	4	(1-	1107		
	3		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type	, Print)	Prince	ehil-	2 Dr	50	ite 101		
		ate	31. Date filed (Month, Day, Year)		Signature			010	ey m	D 5	ite 101		
Dri	Regist		APR 1 9 20	32 Begistrar's S	B A	and I							
UH	IMH 17 Rev 1/2	2001		-	OF	RIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any once. Baltimore, Maryland 21215-0036

> and as the within 24 hours after death To the Funeral Director: filled in by

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) Dav Month Year Physician Ubert Stewart Frank APRIL 2007 /Medical 10:000 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 17, 1917 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 216-01-9435 90 Feb. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Baltimore Timonium Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21093 1 Lucan Court Unit 102 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 ☑ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugenia McClure Ella Stewart Maurice George ဂ္ 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*1 Lucan Ct. Unit 102 Timonium, Md. 21093 19a, Informant's Name/Relationship (Type, Print) Mrs. Eva M. Stewart/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-20-07 Timonium, Md. Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) URINARY TRACT INFECTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END-STAGE RENAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYes 2 No 1∐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Helou, M. D. April 16,2007 DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. H 31. Date filed (Month, Day, Year) M. D. 76 Ø 1 32 Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 HELOU

Registrar

1 Silend

State Registrar 31. Date filed (Month, Day, Year) 32. Regi

Ira Tauber

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

1500 Forest Glen Road Silver Spring, Md 20910
32. Registrar's Signature

DHMH 17 Rev 1/2001

D18813

April 15,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April ^D2007 5 Tucker Veronica

Months Days

7. Age (In yrs. last birthday)

47

4b. City, Town, or Location of Death

Hours

Silver Spring If Under 1 Year If Under 24 Hrs. 3. Time of Death

9. Birthplace (State or Foreign

Washington DC

4c. County of Death

8. Date of Birth (Month, Day,

8-20-1959

Montgomery

2039 pM

Physician /Medical **Examiner**

1 - For State Registrar

5. Social Security Number

578-86-9008

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

6 Sex

1 □ M 2 🗙 F

Funeral Director

death with the Maryland 28a-f show ns 23a or 28a-f shov must be notified at of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

altimore, Maryland 21215-0036

Physician /Medical Examiner and I-transit The law requires that the death certificate be executed physician als the burial-1 as use Division or Vital Records, P.O.

Box 68760,

signed by details has been signed to the second page cate Hospital or Attending Physician: After this death. filled in by the f within 24 hours after To the Funeral Dire

Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Washington Director DC 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20002 USA 1019 16th NE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Home Health Aide 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Ann Tucker Lee Tucker David 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Edfelt Dr, District Heights Md 20747 David Lee Tucker 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood Md Lincoln Cemetery 4-16-07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McLaughlin Funeral Home 21. Signature of Funeral Service Licensee 2019 MLK Jr Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism 4 Hrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Meningioma Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ဥ 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 6, 2007 D 28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 Secu... Second Ave # 404B, Silver Spring Md 20910 Passi Ravi Md 31. Date filed (Month, Day, Year) State Registrar APR 1 9 2007

State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:10 P.M Mary Barna Twiner 2007 15. April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 X F Yrs 220-38-9822 89 Director July 7, 1917 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 717 Maiden Choice Lane ST318 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ፟XYes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify White Specify. ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry the Medical (Give kind of work done during most of working life, DO NOT use retired) ulth and Mental Hygiene.

27 is marked other than "!
r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 5+ Captain USPHS Nursing permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg. Important: If Item 27 is marked other any Injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Barna Julia Cibik ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stamford Avenue: Ft. Walton Beach, FI. 32547
Disposition (Name of Date 20c. Location - City or Town, State Barbara S. Black Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 2122 21. Signature o Funeral Service License 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Life only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trove **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and Due to (or as a consequence of): -burial P.O. Box 68760, physician Physician/Medical that the death certificate the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□ No 24a. Was an has autopsy page perform certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this funeral 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical прletely (Check only and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (are (02515 Choice Maide 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

	•	For State Registrer	11000			ind / Depa	artment of	Health	and N	Mental Hy			12510
Physici	an	Decedent's Name (Fir Wanda	st, Middle, I	_ast) Toms	ski					2. Date of De. April	ath	007 Year	3. Time of Death 8:00 a M
/Medic Examin		4a. Facility Name (If not	institution, o				4b. City, Town	or Location	of Death			county of Dear	
Examin	iei	Manor Care					Catons					Ltimore	
Funeral Director		5. Social Security Number 232–20–5098	er 6	Sex 1□ M 2√xF		s. last birthday) Yrs.	If Under 1 Year Months Day	r If Under	Min.	8. Date of Bir De C. 4,	th	9. Bir	thplace (State or Foreign
pug *		Usual Residence of Dec 10a. State 10b	edent . County		10c (City, Town or Lo	scation						10d. Inside City Limits
Maryla f sho	ō		-	udnel		Severn	, cation						1 ☐ Yes 2 ☐ No
the f	Directo	10e. Street and Number					10f. Zip Code)			10g. Citize	en of What Co	ountry?
h with	a D	7925 Barnl	nill (ircle			211	44				USA	
ems	ner	11. Marital Status			cedent Ever in	U.S. 13.	Was Decedent of		rigin? (Sp	ecify Yes or No	- 14	4. Race - Ame Black, Whit	
s afte	by Funerai	1 Never Married 3 Widowed 4		1 ☐ Yes If Yes, G	2 No live No	i	1□Yes 2≝N			,			White
hours tural,	ed b		Decedent's	Year or Education	Dates:	16a, Dece	dent's Usual Occ	upation			16b. Kine	d of Business	
hin 72	Completed	(Specify or Elementary/Secondary	nly highest o	rade completed	(1-4or 5+)	(Give	kind of work dor DO NOT use reti	e during mo:	st of work	king			,
ad with giene er tha	mo)	12	y (0-12)	College	(1-401 34)	Во	okeeper				Adı	ninstra	ative
Vicilia buld be file Mental Hy arked oth atic evant	Be (17. Father's Name (First	, Middle, La	st)				18. Moth	er's Nam	e (First, Middle,	Maiden S	lumame)	
at yielitid Z i Z i 3-0030 should be filed within 72 hours after deeth with the Maryland didwall by the individual the yields and white the "yields", or items 23a or 28a-f show imetic event. I a Medical Evacular minet to notified at	2	Elwood	N-1-1'	Control Colon	Cawtho			01			0"	Luca	
d 2 st d 2 st th and th and 17 ts n traun		19a. Informant's Name/I			ghter)	1	ng Address <i>(Str</i> e Barnhil						ZIP Code)
pattimiore, interplating ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exerticat must be notified at once.		20a. Method of Dispositi	on		20b		esition (Name of matory or other p			Date		ation - City or	Town, State
DESILITION Department of it mportant: if it my injury or o		`4 □Donation 5 □	Other (Spe	cify)			Cremato		4/16				irginia
Dermij Permij Depar Impor		21. Signature of Funeral	Service Lic	Onsee		22	2. Name and Add			ıdon Par , balti			
		23a, Parti. Enter the di	sease, or co	mplications that	caused the de	ath. Do not ent						, FID Z.	Approximate
Physician		shock, or heart fail Immediate Cause (Fina	ure. List on	ly one cause on	each line.		DE:						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	-		o (or as a cons		y C.	W & 10	11/4				
Examiner		Sequentially list condition	ons,	b									
ed sit	Examiner	Sequentially list condition any, loading to immediate. Enter Underlying Cause (Disease or injury)	fata 🕹	Duals	(or as a cone	aquenne oty:							
xecut and	хап	that initiated events resulting in death) Last		c. Due to	o (or as a cons	equence of):							
ate be executed hysician and the burial-transit	caiE			d									
tificat					M 1.7		7.70				-1		
th certification in the second	an/h	IF FEMALE: 23b. Was decedent preg in the past 12 mon			utcome of preg birth 2 Fe		Ectopic pregnar	псу			23	d. Date of de	livery Day Year
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 No		4□Preç 9□Unk	jnant at time of nown	f death 5	Other (specify)					MOILLI	Day Teal
that the detact	-Ph	Part II. Other significant	conditions	contributing to	death but not r	esulting in the u	nderlying cause	given in Part	l.	23e. Did t	obacco us	e contribute to	the cause of death?
w requires to been signed should be	ed by	TYPE	II	DIAPYE	125 1	nelli	us			1 🗆 '	Yes 2	No 3 P	robably 4 Junknown
aw re	Completed									24a. Was		24b. Were at	utopsy findings available
The i	E O									autor perfo	rmed?	death?	completion of cause of
vicar iclan: ' certilica ector, p	Be	25. Was case referred to examiner?	medical							h (Check only c	one)		
Physic this o	ပ	1 ☐ Yes 2 ☑ No				☐ ER/Outpatier			ursing Ho	ome 5 Resid			city)
ng ng	tion:		Pending investigat		nth, Day Year)	28b. Time o Injury	W	juryat fork? □Yes 2□	l No	28d. Describe f	now injury	occurred	
Atten deat detor:	fica		Could not	be 28e. Place	e of Injury - At	home, farm, str	eet, factory, offic					Number or Ri	ural Route Number,
s atter	Certification:	4 🗍 Homicide	_	buil	ding, etc. (Spe	city)				City or Tov	wn, State)		
To the Hospital or Attending within 24 hours alter death. To the Funeral Director: Alter completely lited in by the fune	edical (29a. Certifier 1 2 0 1 1 2 1 1 2 1 1 2 1 1 2 1 1 1 1 1	Certifying Medicel Ex	aminer: On the	ne best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date a	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	nd manner as place, and due	s stated. e to the cause(s)
ro the	Me	29b. Signature and title	of certifier				29c. Lice	nse number			29d. Date	signed (Mont	h, Day, Year)
->-0			~^	m.D			De	05910	7		04-	13.	2007
6		30. Name and address of	of person wh	o completed car	use of death (It	em 23a) (Type,	Print)	V\$ 0	5 4 5 5	512 3516 200	~ ^	AD 7	112/
Sta	ite	31. Date filed (Month, Da	ay, Year)	32.	Poistrar's Sig	nature	parks		.0171	-1 -1		4 VV 4	11 36
Registr	rar	A	PR 1 9	2007		JOP P							

1 - For State Registrar

	Physici /Medi		Jack	S. Taylor						Apnil	Day	Year 2007	1900 M
+	Examir	ier	4a. Facility Name (If not institution Sirai Hospital	, give street and numb of Baltimu			4b. City, Tow			•	4c. Cour	ity of Death	
	Funeral Director		5. Social Security Number 217–22–2553		Age (In yrs.		nday) If Under 1 Ye rs. Months Da		nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da 2–16–	th ay, Ye <i>ar)</i> 1928	9. Birthpl Count Mary	ace (State or Foreign ry) 'Land
	Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. Cit	ty, Town	or Location Baltimo	re				10	Od. Inside City Limits XXYes 2 □ No
	with the Na or 28a-1	Funeral Director	10e. Street and Number 2721 Atkinso				10f. Zip Coo		2121	1	10g. Citizen o	f What Count	usa
9	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funera	11. Marital Status 1 □ Never Married Never Married	12. Was Decede Armed Force ed 1227 es 2 If Yes, Give	es? No		13. Was Decedent If Yes, spedfy 0		o Origin? (Si xican, Puert)- 14. R B	ace - America lack, White, e	an Indian,
21215-0036	in 72 hours n "natural"; //edical Exa	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highes	st grade completed)		16a. I	Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation		king	16b. Kind of	Business/Ind	
g	I be filed within ntal Hygiene. ed other than " event, the Mec	Be Com	5th 17. Father's Name (First, Middle,	•	or 5+)	Mer	chant Sea			ne (First, Middle	US Mer	chant	Marines
l aryla	2 should be and Mental is marked or raumatic ev	2	George Tayl	nip (Type. Print)		- 1	Mailing Address (Str		umber or Ru		er, City or Tow		
ore, N	ges 1 and t of Health If item 27 or other to		Barbara Taylor 20a. Method of Disposition **XXBurial 2 Cremation	Wife 3 □Removal from St		Place of cemeter)	21 Atkins Disposition (Name of communication), crematory or other	f place)	i	Date		n - City or To	wn, State
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		4 □ Donation 5 □ Other (<i>S</i> 21. Signature of Funeral Service	Decify)	— MD MD	vete arri	ran Cemet son Fores 22. Name and Ac Burgee—H	t dress of F enss-	acility Seitz	3/2007 Funera	Owings l Home,	Inc.	·
	Physician		23a. Part Enter the by ease, or shoot, or heart failure. List				_	dying, suc		Baltimor or respiratory a		yland.	21211 Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or	as a consec	uence o		WA					
S.	ecuted and -transit	Examiner	Sequentially list conditions, if any, but my transport cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as conserved Re		1: Tailure 1: ementia						
Box 68760,	death certificate be executed e attending physician and d for use as the burial-transit		,	Adv	ranu	d De	ementia .						
P.O. Box	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2□Feta nt at time of o	al death	3 ☐ Ectopic pregna 5 ☐ Other (specify				- 1	Date of delive Month	ry Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in	the underlying cause	given in F	Part I.		tobacco use co Yes 2 □ No		e cause of death? ably 4 Donknown
al Records,	The ate his page	Completed								24a. Was auto perfo 1 Yes		prior to con death?	osy findings available inpletion of cause of
or Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hoenital:	oatient 2] ER/Out	patient 3 DOA	Other:		ath <i>(Check only o</i> lome 5 ☐ Res		Other (Specify	·)
Division o	ling After funer	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation	Day Year)		jury M	Injury at Work? 1 ☐ Yes	2□No	28d. Describe			
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determ	inod 28e. Place o	g, etc. (Speci	fy)	m, street, factory, off		te and place	City or To	wn, State)		Route Number,
	the Hos hin 24 ho the Fun apletely	Medical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examin		d/or investigation, in		, death occi		, date and plac	e, and due to	the cause(s)
	To the within To the comple			lero mo						2	Apn		
_	5+1		30. Name and address of person (elián Vo	who completed cause	of death (Iter	m 23a) (Type, Print)	ital	of	Baltir	nose		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign		March 8						
DH	MH 17 Rev 1/2	2001	APR 1	2007 /20	the .	D.	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17, per FH, G867, 5/29/07 WS
State of Maryland, Pepagiment of Health and Mental Hygiene

1- State Amend #1 Per Phy G866 4/23/07 H
Reg. No. 2 1 1 Torbit 2. Date of Death 1. Decedent's Name (First, Middle, Last) James Henry Day Year **Physician** 1:04 PM April 12 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BAITimor union Memoria, HOSP. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min 1 M 2 □ F Days Yrs. 215-52-230 3 Usual Residence of Decedent 1950 **Director** 3 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director MID BATT. MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 nd STREET U.S.A 212/8 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces.

1 DYes 2 □ No
If Yes, Give
Year or Dates: / 9 73 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BIACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PARKING LOTS ATTENDANT None 12 grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Torbit AGA Price ဂ 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City - The Code of Disposition (Name of cemetery, crematory or other place) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores HARR! 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SAKRISON FOREST APRIL 20,207 OwingsMills m) 21. Signature of Funeral Service Licensee CARDINGST. 64/10 ml 1109N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ivel **Physician** disease day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Emphysema
Due to (or as a consequence of): be detached for use as the bunal-trans attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsv performed? after death.

Director: After this certificate 2 No completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B.P. Dave, M.D. 141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital M.D. P-DAVE, BIJAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007 Registrar

			For State Registrar	State of Maryla	nd / Depa			Mental Hygi	2007	26 3
	"放心病者		Hegistrar Decedent's Name (First, Middle, Last)		00,	timoato or E	Journ	2. Date of Death	g. No. U U /	3. Time of Death
1	Physicia		Richard Wile	ey Truff	er			Apri]	Day Year 14 2007	5:50 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			7698 Briar Lane			Pa	sadena		Anne A	rundel
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 1	Year) 1022 9. Bir	thplace (State or Foreign
No.	Director		215-30-3018		73 Yrs.			Sept. 1	8 1933	MD
	land ow		10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Man a-fah	to	Maryland Anne Aru	undel		Pa	sadena			1 ☐ Yes 2 ☒ No
	th the	Director	10e. Street and Number			10f. Zip Code	04400	10	g. Citizen of What Co	
	23a	ral	7698 Briar Lane				21122		USA	
	er de	Funeral		2. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Si n, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ No If Yes, Give Year or Dates:		1□Yes 2□XNo	Specify:		Specify:	White
21215-0036	2 hou	ted	15. Decedeni's Educa	ation	16a. Dece	dent's Usual Occupa	ation	. 1	6b. Kind of Business	/Industry
212	hin 7 9.	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	<i>furing</i> most of wor)			
21	filed within 72 hours after death with the Maryland Hygiene. Hysiene. International Examination rollified at ent. Its Madical Examination rollified at	Completed	12		Part	s & Servi			Industria	1 Trucks
Maryland	e d ita	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M Hoff	· ·	
2	hould d Mer marke matic	2	George Truffe 19a, Informant's Name/Relationship (Typ)		10b Mailie	og Address (Street			City or Town, State,	Zin Code)
<u> </u>	s 1 and 2 should f Health and Mer fem 27 is marke other traumatic		Matsue Truffer	(spouse)		Briar La				L.P 0000)
ō,	s 1 ar		20a. Method of Disposition	20b.	Place of Dispo	esition (Name of matory or other plac	g)		Oc. Location - City or	Town, State
Ë	00-		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movat nom State		ematory I	I AUI'I	1 16 B	altimore,	Maryland
Baltimore,	permit. Pag Department Important: i any injury o		21. Signalure of Funeral Service Licens	111		2. Name and Address			s Funeral	Home, P.A
<u> </u>	895 29		Muschell H.	alleras				ad. Pasad	lena, MD21	122
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused e dea cause on each in .	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Mete	state	> Lu	mp Ca	hees		9mos-
5.7	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		1	To the second second		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
1	uted j insit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
v o	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
-	ys e	ical	. € d.							
89		Physician/Med	IF FEMALE:							
Вох	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregr	al death 3[Ectopic pregnancy			23d. Date of de Month	livery Day Year
o	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5L	Other (specify)				
٦	The law requires that the tee has been signed by the sage 2 should be detached.	by Ph	Part II. Other significent conditions cont	ribuling to death but not re	sulling in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	quires en sign uld be							1/X Yes	s 2 □ No 3 □ P	robably 4 Unknown
Records,	aw requir ts been si 2 should I	Completed						24a. Was an autopsy		ulopsy findings available completion of cause of
		E O						perform		Λ
Vital	nysician: nis certifica director, f	Be	25. Was case referred to medical examiner?					th (Check only one)	
0	Physis this c	2	T Tes Zyg No	1 ☐ Inpatient 2 [28a. Date of Injury	ER/Outpatier		4 Nursing n		nce 6 □Other (Spe	ecify)
u C	Attending Physician: In death. ector: After this certifica by the funeral director.	ion	27. Manner of Death Natural 5 Pending Naccident investigation	(Month, Day Year)	28b. Time o Injury	Worl	/at ⟨? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	ii or Attendi after death I Director: A d in by the fo	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	nome, farm, sti				eet and Number or R	ural Route Number,
2	alor/ s after I Dire d in b	Certification:	4 Homicide	building, elc. (Spec	ify)	•		City or Town,	State)	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my of	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	vithin i	Mec	29b. Signature and title of conflier		,	29c. License	e number	29	d Date signed (Mon	th, Day, Year)
	->=0		T/ fin	10111		- /	13155	1 +	April 1	6.7007
	1.0		30. Name and address of person who pon	mpleted cause of death (Ite	em 23a) (Type,	Print)	Λ Λ		10	1 21-11
	18		Kussell Kide	Men 10	30%	H0501-	tal US	we, 6	lenewoir,	Not 2/06/
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2007	32. Registrar's Sign	nature				,	
100			WILLY O FOOL	The state of the state of the state of	The same of the sa	P. S. C.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** WALKER EEN APRIL 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** BALTIMORE 5. Social Security Number 9. Birthplace (State or Foreign Country)

SouTH CAROLINI If Under 1 Year 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday **Funeral** 1□ M 2**X**F Director Usual Residence of Deceden with the Marylend 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heelth end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at 10d. inside City Limits 1 XYes 2 □ No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? CHASE STREET UNITED STATES

14. Race - American Indian, Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 25 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes No Specify: ρ Specify: BLACK 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ABORER unK INDUSTRIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK GENEVA ASPER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONAWAY 308 WOODLAWN, MD 20a. Method of Disposition 20c. Location - City or Town, State 3 DRemoval from State WOODLAWN CEMETERY APRIL 17,2007 4□Dongligh WOIDLAWN, MD 5 Other (Specify) us Miller's METROPOLITAN CHAPEL 1639 N. BROADWAY Part1. Emer the shock or heart fa e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. immediate Cause (Finel **Physician** Noure MYOCAPDIO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 30 サイトマンケでいい Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 1 9

Krow

29c. License number

070EC.

For

29d. Date signed (Month, Day, Year)

411610)

and manner stated.

hil

32. Registrar's Signature

500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WINETON

2007

07-02790	
John Wilson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

III VVIISOII		State of Maryland / 1- For State Registrar		icate of Death			eg. No. 200	7 1261
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last) John Day:	id Wils	son		2. Date of Dea Month April 12, 2	Day Year	3. Time of Death 2243 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital			own, or Location of		4c. County of Dea	ath
Funeral			e (în yrs. last i	birthday) If Under	1 Year If Under		rth(MM/DD/YYYY) 9. E	
Director		214 92 2794 1XM 2F	35	Yrs. Months	Days Hours	Min. 11/02	/1971 Fore	Country) Maryland
, any	- 1	Usual Residence of Decedent 10a. State 10b. County		wn or Location		-	·	10d. Inside City Limits
ryland a-f shov	cto	Maryland N/A	Вал	Ltimore 10f.Zip	Code		10g. Citizen of What Co	1 X Yes 2 No
nith the Maryland 123a or 28a-f show s notified at once,	Directo	521 Maude Avenue		1	21225		U.S.A	•
eath with items 2 ust be n	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?			it of Hispanic Origin Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - Am White, etc.	erican Indian, Black,
s after de ral", or	by Fu	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		1 Yes 2				hite
72 hour n "natu al Exan	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		ia. Decedent's Usual C during most of work	ting life. DO NOT u		16b. Kind of Busines	s/industry
-003(d within rgiene. ther tha	omp	12th 17. Father's Name (First, Middle, Last)		Truck D		Name (First, Middle,		sportation
1215-0036 Id be filed within 72 Aental Hygiene. narked other than event, the Medical	Be	David J. Wils		101 M 15 A 11	1	Patricia R		
MD 2 2 shoul 3h and M 27 is m umatic	ը	19a. Informant's Name/Relationship (Type, Print) Patricia Wilson / Mother		521 Maude	•		mber, City or Town, Sta re, Marylar	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	ate crer	ce of Disposition (Nam matory or other place)	.	Date	20c. Location - City	
Baltim permit. Pag Department Important: injury or o		4 Donation 5 Other Specify: 21. Sign or of Funera Service Licensee	Вау	view Crema	Address of Facility	4/18/2007 Gonce Fu	neral Servi	re, Maryland
M N N N N N N N N N N N N N N N N N N N	5 10	23a. Part/. Enter the disease, or complications that caused	the death. Do		itchie Hi	ighway Bai	ltimore, Ma	aryland 21225
/Medical	G 734	failure. List only one cause on each line. Immediate Cause (Final disease a Heroin into						Between Onset and Death
,xa		or condition resulting in death) Due to (or as a conse	equence of):					
	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	equence of):					
d d ansit	Examine	events resulting in death) Last Due to (or as a conse	equence of):				-	
760, reate be executed g physician and the burial - transit	Medical	X UNPENDED AMERICA, 28	Ba-f, pe	rME, g866, 4/	/26/07 TT			
Division of Vital Records, P.O. Box 68760, or the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clast. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor 1 Live birth		2 Fetal death	3 Ectopic	pregnancy	23d. Date of deliving Month	rery Day Year
Box 687; death certificathe attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	time of	5 Other (Spec	ify)			
P.O. s that the gned by e detache	by	Part II. Other significant conditions contributing to deat	h but not resu	Iting in the underlying	cause given in Par		tobacco use contribute es 2 ✓ No 3 P	to the cause of death?
Division of Vital Records, P.O. Balander and Attending Physician: The law requires that the de ris after card. Al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for	Completed					24a. Was	ppsy prior t	autopsy findings available to completion of cause of
Recc The lar ficate ha	Comp					1 ✓ Yes	ormed? death 2 N 1	
ision of Vital Rec Attending Physician: The I r death. retor: After this certificate I by the funeral director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗸 EF		OA Other	Nursing Home 5	Residence 6 Ot	her:
n of iding Plant. After efuneral	ion: T	27. Manner of Death 1 Natural 5 Panding 28a. Date of Inju (Month, Day, V			8c. Injury at Work?	l	how injury occurred	
Vision or Attence free death Director: in by the	Certification:	2 Accident Investigation Fn0 4/12 3 Suicide 6 X Could not be 28e. Place of Ir		Fnd 10:52 pm e, farm, street, factory,		28f. Location	(Street and Number or State)	Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a, Certifier	ouse ov knowledge	death occurred at the	time date and place		State) de Ave. Balti	
To the I within 2. To the F complete	Medical	one) 2 Medical Examiner: On the basis of exa	mination and/	or investigation, in my	opinion, death occ	curred at the time, date	e and place, and due to	the cause(s)
2)	Z	29b. Signature and title of certifier		290.	O.C.M.E.		April 13, 2007	viontn, ∪ay,Year)
Sch		30. Name and address of person who completed cause of o			altimate MD (21201	<u> </u>	
S	tate	Ana Rubio MD. Assistant Medical Exan 31. Date filed (Month, Day, Year) 32. Registra	niner 11 ar's Signature	1 Penn Street, B	aitimore, IVID			
Regis	4	ADD 1 0 2007 Fee.	M.	Constel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7.9 perFH. G866, 4/19/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyghen.

The 27 is marked other than "natural" or Items 23a or 28a-1 show then 27 is marked other than "natural" or Items 20a. 1 □Yes 2 Txt No Funeral Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12 Rosedale Avenue 21061 U.S.A. Was Decedent Ever in U.S. Armed Forces? 1Ži Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Maker Glass Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence S. Wentworth Barbara Marie Warner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Scheleur/daughter 452 Century Vista Drive; Arnold, MD 21012 Pages 1 ent of Hee Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or Injury or 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 04/19/2007 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed physician and strans Due to (or as a consequence of): P.O. Box 68760. as nse s IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 Other (specify) the ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? certificate 2**2**1No 2□ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 P N 1 Impatient 2 ER/Outpatient 3 DOA this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0052950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GrazNe ZIAI HMORE

DHMH 17 Rev 1/2001

State

Registrar

sou th

APR19

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Manylim

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MM

one)

32. Registrar's Signature

5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

12

29c. License number

LULY MMON SUM

D15135

29d. Date signed (Month, Day, Year)

APRIL 15, 2007

SMIMUNE

			For State	State of Ma	rylan				lealth a	and M	,	•	0.0	947	4 1%	e I 0
			Registrar 1. Decedent's Name (First, Middle, Last)			Cei	uncai	eori	Dealli		2. Date of De	Reg. No.	20	17	2 time 24	5 8
	Physicia	an									Month	Day	200	ear	10.20) A M
	/Medic		Lilli Turk Zeren 4a. Facility Name (If not institution, give s	stroot and number)			4h City	Town or	Location o		April	17,	200 County of		10:30	J A "
į.	Examin	ier	1	realth Cen	uter					JI Dealli			BALT		V	
	Funeral		5. Social Security Number 6. Ses	•		last birthday)		r 1 Year	If Under 2	24 Hrs.	8. Date of Bir	atla			place (State or	Foreian
	Funeral Director]M 2 X ∫F	93	Yrs.	Months	Days	Hours	Min.	JAN 26	$\frac{19}{19}$		Coui	MD	
			Usual Residence of Decedent	1			l				0111, 10	,				
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							1	I 0d. Inside City	
	a-fs iffied	cto	MD Baltimore	<u> </u>	Tow	son									1 ☐ Yes	2 X No
3	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wh	at Cour	ntry?	
	z should be liled within 72 hours after death with the Maryland, and Mental Hygiene. I am Ameria Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the M-dk-al Examiner must be notified at	Funeral Director	1055 W. Joppa Rd					204				USA				
	tems term	nue	11. Waltar States	12. Was Decedent Every Armed Forces?		S. 13.	Was Dece If Yes, spe	dent of H	ispanic Orig an, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.))-	 Race - Black, 			
9	or il	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give)		1 ☐ Yes	2 X No	Specify:				Specify:	r.7l., .:	+ -	
	nours tural	D D		Year or Dates:		16a. Dece	dont's Her	al Occup	ation			16h Ki		Whi		
2 8	"nat	Completed	15. Decedent's Edu (Specify only highest grade	e completed)		(Give		rk done d	during most	t of worki	ng	100. KI	nd of Busir	1622/111	dustry	
7	with ene. than he M	ᇍ	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse			,			John	s Hon	kin.	s Hospi	tal
ָ ב	Hygi ther int, t		17. Father's Name (First, Middle, Last)			rarbe			18. Mothe	er's Name	(First, Middle			1111	о поорт	CGI
5	d be ental ced o	o Be	Karl Turk, Sr.						Li11:	i Kla	ານເຂົ້ອ		,			
	mark matt	ဍ	19a, Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	ng Addres	S (Street a			Il Route Numb	er. City o	r Town. St	ate. Ziu	Code)	
2 2	Ithar Ithar 27 is 17 is		Karl J. Zeren/Son	,			_				nium, M				,	
ນົ .	permit. Pages 1 and 2 should be filed within 7.2 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-di-al Examiner must be notified at once.		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei					ate		cation - Ci	ty or To	own, State	
	y or		1 ☐ Burial 2 XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	1	tro Cr			1	/ ₁ /1 Q	/2007	Dol1	timon	• 1	MD	
!	ortan		21. Signature of Funeral Service License	ee C. Todd		no 2	2. Name a	nd Addres	ss of Facilit	4/10 ty	-	Dall	timor	e,	עוצי	
Ö	Department of the concernation of the concerna		1. (1.600)	. C. 10dd	DLI	ng C	rema	tion	Socie	éty (of Mary altimor	land	,Inc 的 212	້ຳຂ		
	S. L. Ville		23a. Part1. Enter the disease, o compl	ns that caused t	he death								W 412	220	Approximate	
	hysician		Immediate Cause (Final	ne cause on each line		th one	26	100	neut	٠ هـ.					Onset and D	
	/Medical		disease or condition resulting in death)	Due to (or as a			00		.01(1	19				+	year.	
E	Examiner															
١,		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	uence of):										
V .	cuted nd ransi	Examiner	that initiated events	s												
5	e exe ian ai ırial-1		resulting in death) Last	Due to (or as a	consequ	uence of):										
0 .	cate be executed oblysician and the burial-transit	dical		d										_		
	w requires mat me deatn certific been signed by the attending p should be detached for use as t	Mec	IF FEMALE:													
ָ ס	ath ce ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome p 1☐Live birth 2	Feta	Ideath 3	Ectopic p		/			1	23d. Date of Month		*	ear
	the a	sici	1 ☐ Yes 2/3 No 9 ☐ Unknown	4∐Pregnant at t 9∐Unknown	ime of d	eath 5	Other (s	pecify)					WOTO	•	Day	Cai
	I ne law requires mat me deam cerning tate has been signed by the attending page 2 should be detached for use as	문	Part II. Other significant conditions con	ntributing to death but	not resi	ulting in the u	nderlying	valueo divi	en in Part I		23e Did	tobaccou	ise contrib	uto to t	he cause of de	anth?
Ų.	res ri signe be d	þ	Ceali DI		1101 1630	anding in the d	inderlying (ause givi	en in raiti.	•					pably 4 ⊟U	
ecords,	requi	Completed by	Junivia Januve	to Thrive							,,,	103 2/			Dably 4 0	IIKIIOWII
. E	e 2 si	ğ									24a. Was auto	psy	pric	or to co	opsy findings a impletion of ca	vailable use of
	cate l	ပ္ပြ									1∐ Yes	ormed? 2 No		ath?]Yes	2□ No	
֓֞֞֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֟֓֓֓֓֟֓֓֓֟֟֓֓֓֓֓֓	clan ertific	Be	25. Was case referred to medical examiner?	Z2a-4.		_		10"		of Death	(Check only	one)				
5	rnysi this c	은	1 1e3 2 110	Hospital: 1 ☐ Inpatien		ER/Outpatier			4 Nu		me 5□Res				fy)	
	After uners	ii o	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day		28b. Time o Injury		28c. Injur Worl	k?		28d. Describe	how injur	y occurred			
<u>ק</u>	tend eath. tor: / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2□I							
2	fter d Jirech n by	Certification:	4 Homicide determined	28e. Place of injur building, etc.	y - At ho (Specify	ome, farm, str y)	reet, factor	y, office		12	28f. Location (City or To	Street an wn, State	d Number e)	or Run	al Route Numb	ber,
ָ נ	pital urs a eral L illed i		One Contiller ST-Contilling St	cicion. To the base	F page 1	wlodeo dest	h occurre	l at the t	mo data	ad minor	and direct of		and -			
:	I of the hospital of Attending Prysician: The lay within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical		sician: To the best of ner: On the basis of and manner stat	examina											
;	ithin 2	Med	29b. Signature and title of certifier	and mailler stat	ou.		29	c. Licens	e number			29d. Dat	te sianed (Month	Day, Year)	
١	= ¥ ₹ 8	_	DA PARADA	\sim						3		AOR	LL	17	7-007	
,	1		- Contract			00e\ (T	Dair 4)					17.		/ 1	7 50)	
	b		30. Name and address of person who co	Displeted cause of de	G70) N (Type	Lov	Les	St .	Tow	son h	107	2120	f		
	Sta	ato	31. Date filed (Month, Day, Year)	32. Registrar	0	, , ,				, -						
		ate			_	20	1 0	-								

			1 - For State Registrar	State of M	larylan	_	artmen <i>tificat</i>			nd Me	_	iene eg. No.	007	12619
П	Physici	an	Decedent's Name (First, Middle, Last								Date of Dea Month	th Day	Year	3. Time of Death
1	/Medic	al .	Veronica	2106			45 005	T	A acadian of	(Daret	april	18	2007 unty of Death	8:40 AM
	Examin	er	4a. Facility Name III not institution, give Howard County G	eneral Ho	spita	1	4b. City,		Location of umbia				Howard	
	Funeral Director			ex 7. A □ M 2 3 ¢F	ge (In yrs. I 101	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Month, Day June 28	,1905	9. Birth Cou	place (State or Foreign untry) PA
	and and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation			_				10d. Inside City Limits
	Mary	호	MD Howar	ď			Co.	Lumbi	.a					1 X Yes 2 □ No
	h with the 23a or 28a at be noti	al Director	10e. Street and Number 8578 Hayshed La	ne			10f. Zip	Code 21	.045		1	0g. Citizer	of What Cou USA	untry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28s-f show any fujury or other traumatic event, Ite Madical Examiner must be notified a page.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	1	Was Dece f Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No- lican, etc.)		Race - Amer Black, White pecify: Wh	
ς Q	72 ho	etec	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usu kind of wo	al Occupa	tion uring most	of workin	g	16b. Kind	of Business/I	ndustry
121	within ne. then "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. I		se retired) emake				Ow	n Home	!
land 2	ld be filed v ental Hygie ked other i ic event, II	To Be Co	17. Father's Name (First, Middle, Last) Andrew Motiska)					18. Mother	r's Name San	(First, Middle, Stupak			
Maryland	alth and M	-	19a. Informant's Name/Relationship (David Ziobro / S	Type, Print) SON			-				Route Number	-		ip Code)
Baltimore,	Pages 1 a lent of He int: if item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)		1 6	lace of Dispo emetery, cren t Oliv	natory or o	ther place	ry A		23,200°		ion - City or 1	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	L. Mous	liall	22	harf 501	ad Addres Es L. East	s of Eacility Stev Fort	vens Aver	Funera nue, Ba	l Hom Itimo	e Inc. re, MI	21230
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death	n. Do not ent	er the mod	te of dying	, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Con	aestin	· Ha	sut	Faile	ine.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	dence of):					ular c			7
		-6-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	a consequ	uence of):	roh	Car	dior	034	ular c	lised	re	years_
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											,
8760~	ate be executed hysicien and the burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequ	uence of):								
376	ate be hysici	Icai	•	d										
P.O. Box 6	Attending Physician: The law requires thet the death certificate be executed rideath. sctor: Atter this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic p					230	I. Date of delined Month	very Day Year
٩.	thet if ed by detac		Part II. Other significant conditions of	contributing to death	but not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ds,	uires sign ld be	d by									1 U Y	es 2 2	√0 3 □ Pro	obably 4 Unknown
CO	w requires to the second secon	Completed	apratum	0000	· cho						24a. Was a	an 2	24b. Were au	topsy findings available
Re	The lay te hes age 2	E O	- april and	V GAINAO	76/1						autop: perfor	med?	prior to death? 1 ☐ Yes	completion of cause of
ita	lan: rtifice stor, p	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 10
<u>~</u>	hysic his ce I direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Impat	ient 2 🗆	ER/Outpatier	nt 3□ D0	Othe	ir: 4 ☐ Nu	rsing Hom	ne 5 🗆 Resid	ence 6	Other (Spec	cify)
Division of Vital Records,	ittending Pi death. ctor: After ti / the funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ury ay Year)	28b. Time of Injury	f M	28c. Injury Work	at ? ′es 2 ☐ N		8d. Describe h	ow injury o	ccurred	
D <u>ixi</u>	tal or Att is after de al Directi ed in by t	Certification:	3 Suicide 6 Could not b	289. Place of It	njury - At ho etc. (Specif	ome, farm, str y)	eet, factor	y, office		2	8f. Location (S City or Tow	treet and N n. State)	lu <i>mb</i> er or Ru	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Medical Example 1	nysician: To the bes miner: On the basis and manner s	of examina	wledge, death tion and/or in	h occurred vestigation	at the tim	e, date and inion, deat	d place, a th occurre	nd due to the d d at the time, d	ause(s) an late and pl	d manner as ace, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29	c. License	number		4	9d. Date s	igned (Monti	n, Day, Year)
•	_/		1 / N	10				0-5	3636			Mr.1	18,	2007
	Do		30. Name and address of person who IFCV IN BISITED STATES APR 19 2	completed cause of	death (Item	1070	Print)	mt	21 6	rive	Cours	mhic	us	21044
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 9 2	007 32 Regis	trar's Signa	Ture Co	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1815, 2007 Month **Physician** Maxwell Zents Harry Mori /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 510 Mona Brund Washington MHALLEI Unrniy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1**X** M 2□F 174-16-7451 87 February 1, 1920 Director Pennsylvania Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Odentan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Odenton Road 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than 12 years Port Captain Towing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Harry Zents Alma Maxwell ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Health tem 27 I John D. Zents son 1900 Thames Street, Unit 201, Baltimore, MD. 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aprilate 21, permit. Pages Department of Important: If it any Injury or o once. 1 Burial 2 Cremation 3 Removal from State Lakeview Memorial 2007 Sykesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease or complications that caused the dath. shock, or heart failure ist only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 0000 **Physician** 287 disease or condition resulting in death) /Medical Due to (or as a contequence of): Examiner Ũ Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as Examine The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★No 24a. Was an autopsy performed? res 2 No After this certificate has 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 hpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1- Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 4 hours after death. death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a **To the Funeral C** To the Hospital 29a. Certifier (Check only one) TS/certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

Registrar

Division or Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Régistrar's Signature

BUR

APR 1 9 2007

31. Date filed (Month, Day, Year)

		1 - For Stata Registrar	State of Maryland		rtment of Hea			ene . No.2 0 0 7	12621
		1. Decedent's Name (First, Middle, Las	1)			2.	Date of Death	Day Year	3. Time of Death
Physi /Med		WILLIAM HEN	RY ZEIDLER,	Sr.			Month	18 2007	01414
Exam		4a. Facility Name (If not institution, give		,	4b. City, Town, or Local	ation of Death	,	4c. County of Death	
		Dince Hospi			Baltin	on les	ry	N/A	
Funera		5. Social Security Number 6. Se	לו יחב ו	st birthday) Yrs.		ours Min.	Month, Day, Y	(ear) Cou	place (State or Foreign ntry)
Directo	r	218-10-1422 '4 Usual Residence of Decedent	87	113.		Nc	ov. 27,	1919 Mar	yland
/land		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Man	ţ	Maryland N/A	Ва	altimo	re				1 X Yes 2 □ No
ith the Marylan or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
th wil	alc	733 Stoney Sprin	g Drive		21	210		U.S.A.	
r dee	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Specify exican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ameri Black, White,	
s afte	by Fi	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: 1941-4	15	☐ Yes 25 No Sa	ecity:		Specify: LTb	ite
hour furai		15. Decedent's Ed			ent's Usual Occupation		16	ib. Kind of Business/Ir	
n n	Completed	(Specify only highest grad	de completed)	(Give k	ind of work done during O NOT use retired)	g most of working	10	,	
y with	Ē	Efementary/Secondary (0-12)	Coffege (1-4or 5+) 5+ years	Ele	ctrical En	ngineer		Telephor	ne Company
other the	BeC	17. Father's Name (First, Middle, Last)			18.	Mother's Name (F	irst, Middle, Ma	iden Sumame)	
Wents Wents wiked	<u>ام</u>	John Frederick Ze	eidler		I.	laude	Win	iters	
2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show aumatic event, its Medical Examinations to a collised at	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street and I	Vumber or Rural R	oute Number, C	City or Town, State, Zi	o Code)
end eeth m 27		<u>Kathleen Zeidler</u>	(wife)		toney Spri				
Pages 1 nent of H int: if ite		20a. Method of Disposition 1 🗆 Burial 2 🔀 Cremation 3 🗀	000	ce of Dispos netery, cremi	ition (Name of atory or other place)	Date	20	c. Location - City or T	own, State
Pag tmen tant:		4 Donation 5 Other (Specify			nt Cremato			altimore,	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23a or 28a-1 ehos any injury or other traumatic event, its Medical Examinar must be notitined at		21. Signature of Funeral Service Licen	wase.	²² M	Name and Address of itchell-Wie 6500 York 1	edefeld I Road Bal	Tuneral Ltimore	Home, Inc Maryland	. 21212
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death.	Do not ente	r the mode of dying, su	ch as cardiac or re	espiratory arrest	t,	Approximate Interval Between
Physician	า	Immediate Cause (Finaf disease or condition	. Acute le	unia	raid la	fareti	n		Onset and Death
/Medica		resulting in death)	a. Acute le	nce of):					
Examine		Saquantially list conditions	b. Hyperkal	eme	L				
ed slt	-loe	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due toter as a conseque	ince of):					
xecut and ul-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ince of):					
be e Bicien				,					
ficate pphysics the	edical		d						
nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance					23d. Date of deliv	ery
death death death	C a	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		Ect <i>o</i> pic pregnancy Other <i>(specify)</i>			Month	Day Year
by the	hys	9 □ Unknown	9□ Unknown						
ss tha		Part II. Other significant conditions co	ontributing to death but not result	ing in the und	derlying cause given in	Part I.		cco use contribute to	
en si	ed	hypertension					1 🖭 Yes	2 ™ 0 3 □ Pro	babfy 4 ☐Unknown
lawr as be	ompleted by						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
The The ete h page	Con						performe	d? death? 1 ☐ Yes	
cian: ertific ector.	Be (25. Was case referred to medical examiner?				Pface of Death (C	heck only one)		
hysi this c	ဥ	TEL es 2 140		R/Outpatient				ce 6 ☐Other (Speci	fy)
ling F	<u></u>	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	8b. Time of Injury	28c. fnjury at Work?		I. Describe how	injury occurred	
death death itor:	cat	2 Accident investigation 3 Suicide 6 Could not be	1	o form atra	M 1 Yes		Location (Stra	et and Number or Rur	al Pauta Number
or A Direction by	ertification:	4 ☐ Homicide determined	building, etc. (Specify)	10, 12/111, 50/0	er, ractory, brince	201.	City or Town,		ar riodig realinger,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	edical C	(Check only 2 Medical Exam	ysician: To the best of my knowl iner: On the basis of examination						
thin 2 the in the in	Med	one) 29h Sinnature and title of certifier	and manner stated.	-	29c. License nur	mber	294	I. Date signed (Month,	Day, Year)
F 3 F 8		> Redened.	du I		MO P40	693	A	pril 18, 7	•
H		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, P	rint)			. ,	
. /	į.	ALDEN (7. PEOP	VES, NO SIN	m Has	PITAL OF	BACTIMO	RE		
S Regis	tate strar	29b. Signature and title of certifier Pulling 30. Name and address of person who of the person who of the person who described and the person who described and the person of the pers	7. Registrar's Signatu	THE STATE OF THE S	the of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2:20 P M Hector C. Avelar Apri1 5 2007 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23099 Marshall Road Lexington Park
If Under 1 Year | If Under 24 St. Mary's 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 02/16/1939 Director 526-56-1325 68 Arizona Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director <u>Maryland St. Mary's</u> Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23099 Marshall Road 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 11∏ Yes 2□ No Specify: Latino \$ Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Logistics Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pedro Avelar Maria Guadalupe Carlos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23099 Marshall Road, Lexington Park, Maryland 20653 Roberta Avelar/ Wife permit. Pages 1 a
Department of Hei
Important: if item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2007 | Arlington, Virginia <u>Arlington National</u> 22 Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsecurinos off Examiner certificate be executed the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the attent detached for u atten 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2□ No 3 Probably 4 NUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy page performed' certificate 2 DV6 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) 07 991 10 30. Name and addr perso who con eleted cause of death (Item 23a) (Type, Print) James C, Boyd, 23415 Three Notch Road, California, Maryland 20619

DHMH 17 Bev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007

egistrar's Signature

		•	For State Registrar	State of M	Marylan			nt of H		and M		giene Rag. No.	007		12523
Phy	sicia	n	Decedent's Name (First, Middle, La			Po					2. Date of Dea Month	Day	Yee		3. Time of Death
	edica		4a. Facility Name (If not institution, giv	abeth		ЪО	ppe	Town or	Location o	of Dogsth	April	13	200 County of De		9:10 A M
Exa	mine	er	76 Sunbrook Lane		er)			ersto		n Death			Vashin		m
	-		5. Social Security Number 6. S		Age (In yrs. i	ast hirthday)		r 1 Year	If Under:	24 Hrs.	8. Date of Birt	h		<u> </u>	ce (State or Foreign
Fune Direc				□M 2 ∑ F	87	Yrs.	Months	Days	Hours	Min.	June 4	v. Year)	1 4	Countr	land
		1	Usual Residence of Decedent								ounc 4	9 1/1		<u> </u>	20110
laryland •how	4		10a. State 10b. County		10c. City	, Town or Lo	cation							100	d. Inside City Limits
Mar	4	jo	MD Washin	gton		Hagers	town								1X Yes 2 ☐ No
r 28		rec	10e. Street and Number				10f. Zi	p Code				10g. Citiz	en of What	Countr	y?
h witl			76 Sunbrook Lane	!				21742	2				U.S.	Α.	
deati ms 2		Funeral Director	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Dece	dent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	. 1	4. Race - Ar		
or Ite	2	2	1 ☐ Never Married 2 ☐ Married	1 Tes 2 (1 🗆 Yes	37	Specify:	i, rueno r	nican, etc.)		Black, WI		
ours ours		ğ	3 X Widowed 4 ☐ Divorced	Year or Date	s:		1 4 1 63	21.3140	эрвспу.			y-55-	Specify: W	Vh1t	e
72 h		Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)		16a. Deced (Give	kind of wo	ork done d	uring most	t of workir	ng	16b. Kin	d of Busines	ss/Indu	istry
ithin		du	Elementary/Secondary (0-12)	College (1-4d	or 5+)	_		ise retired))			T	niture		
led w	3		47 Salbada Maria (Siant Middle Land			Secre	Lary	1	10 11-41-	-1- No	(Fire A A Sintalla				
d al d		Be	17. Father's Name (First, Middle, Last)	1							(First, Middle,	маюелз	sumame)		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.		ို	Fred L. Fales			1				,	tt Bell			_	
2 sh and is m			19a. Informant's Name/Relationship (•	,			Route Numbe				
1 and Health			Gary L. Boppe/Son		20h B						oad, Be		dam, V		23015
Pages 1 nent of F	5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from Sta		lace of Dispo emetery, crer									
) and		4 □ Donation 5 □ Other (Special	·	Res	st Have							rstown	-	
permit. Depart	DICE		21. Signature of Funeral Service Lice	1500							st Have				
4 405	a		y s. ruck s	M			-				ve., Ha	_	town,	-	
Physic /Medi Exami	cal ner	-	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to	yline. OR as a consequence as a consequence	uence of):			- 1		-Vaco	V	(G) E	ľ	Approximate nterval Between Onser and arth
o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. AC	CIFI as a consequence (UC=	LACE OF COLUMN	a TRC	PIS	(U)	()C	5(A5)	= 1	tu	/	/ 1045
that the death certific	200	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal	death 3	Ectopic p	pregnancy				2	3d. Date of o		y Day Year
res that	500	by P	Part II. Other significant conditions	contributing to deal	h but not rest	ulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco us	se contribute	to the	cause of death?
uires Sign			HURGITENS	en. H	TACA	-FU	ACC	CATZ	W		1 🗆 Y	es 25	€ √0 3 🗆	Probal	bly 4 □Unknown
w requ	Dinous	Completed	RINDUALIER	KUMGER	ment	-1/6					24a. Was	an	24b. Were	autops	sy findings available
he lav	2	m d	DIA TO COLOR	140	7	0.046						med?	death	?	pletion of cause of
sician: Th	2	ပိ	25. Was case referred to medical	1791	ent n	Orther			00 01	-4 Darath	1 Yes	21 No	1 U Y	es 2	! ∐ No
sicia		Ö	examiner?	Hospital:	ationt O	ED/Outpation		Othe	\F-		Check only o		D0:5 /0	6 1	
Phys rthis	<u> </u>	- 1	27. Manper of Death	1 ☐ Inpa	njury	ER/Outpatier 28b. Time of		07	4 🗆 140		ne 5 🔀 Resid 28d. Describe f			р <i>өспу)</i>	
Afte.		į	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		Day Year)	Injury	м	28c. Injury Work 1 🔲 Y	:? ∕es 2 🗆	No					
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After	completely rited in by the turleral director, page	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factor	ry, office		2	28f. Location (S City or Tox		Number or	Rural	Route Number,
ne Hospit 24 hours ne Funera	netery rate	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Madical Example)	nysician: To the be minar: On the basis and manner	s of examina	wledge, death tion and/or in	occurred vestigation	d at the tim	e, date an pinion, dea	id place, a	and due to the e	cause(s) a date and	and manner place, and c	as sta due to t	ted. the cause(s)
To the Within	E	Ž	29b. Signature and title of contiller		>		29	c. Limose	number			29d. Date	signed (Mo	opth, D.	ay, Year)
			Much	TAUNG	1445	10 lin	1	()	170	16)	4	113/	200	
		İ	30. Name and address of phrson who	completed cause of	death (Item	23a) (Type,	Print)	D	6	11			1	/	61-
	8		STEPHEN E. TUE	TENCH,	and	134	241	al	WE.	100	Accen 17	Q.CC	n, W	do	21747
elle.	Stat	-	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ture				. 1					
Do.	nietra	17	300 d a 444	R.	11.0		all								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1	- For State Registrar <mark>Amend#8 - Per</mark> 1 Decedent's Name (First, Midd	FHPGC4-5-	07cr Cer	tificate of	Death				Reg. No.		Lo Time of Death
Physicia dical Examin	ner	Stanly B	radley						Date of De Month March 3	Day 1, 20 0 7	Year	3. Time of Death 0725 hrs
		4a. Facility Name (if not institution Prince Georges Hosp	-	ımber)		Cheverly				Prin	ounty of Deat	e's
Funeral Director		5. Social Security Number 579/92/0979	6. Sex	7. Age (In yrs. la	ast birthday) 37 Yrs.	If Under 1 Months	Year If Ur Days Ho	urs Min.	8. Date of B	3irth(MM/DD 1969 / 2007	9, Bi Forei C	nth lace (State or grounding Washington) ountry) DC
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygin Mental Hygin 27 is marked other than "natural", or items 23a or 28a-f show any 27 is marked other than "natural", ar items 23a or 28a-f show any innatic event, the Medical Examiner mast be notified at once.	Director		12. Was Der Armed F 1 Yes vorced If Yes, Give Ye or Dates: ecify only highest gra	ceedent Ever in U. orces? 2 No ar de completed) 1-4 or 5+)	If Y	ngtor 10f. Zip Co 20 (s Decedent Ces, specify C Yes 2 t's Usual Occost of workin	of Hispanic Cuban, Mexico No specicupation (Gig life, DO No	ive kind of wo	tican, etc.)	US No- 14 Sp	4. Race - Ame White, etc. pecify: B d of Business	rican Indian, Black,
1215-0036 be filed within 7 nital Hygiene. irked other than vent, the Medica	å	17. Father's Name (First, Middle Stanly Br	adley	1			18.Mot	her's Name (sie J	e, Maiden Su Ohnsc	urname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical		19a. Informant's Name/Relation Elsie Bradle 20a. Method of Disposition 1 XXBurial 2 Crematic 4 Donation 5 Other S 21. Signat Funeral Se	y, Mothe	20b.	1924 Place of Dispos crematory or ot rmony	Ridge sition (Name her place) Cemet	ecres of cemetery, tery dress of Fac	t Crt 4/7	#202 Date 7/200 vlors	Wash 20c. Loo 7 Lar Fune	ndove eral B	20032 or Town, State
Physician /Medical Examiner		23a. Part I. Enter the disease, failure. List only one caut Immediate Cause (Final diseas or condition resulting in death)	e a <mark>Head Injur</mark>	caused the death	n. Do not enter t	he mode of c	OFTN_dying, such a	cap1t	respiratory	T INW arrest, shock	was <u>n</u> k, or heart	DC 20001 Approximate Interval Between Onset and Death
760, cate be executed physician and the burial - transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	e c	a consequence of								
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes 1 Live 4 Preg	, outcome of pre birth gnant at time of d	2 Felleath 5 0	etal death ther (Specify underlying ca	()	topic pregnar	23e. D	Mid tobacco us		Day Year to the cause of death?
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certification of hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by					36	Place of De	eath (Check o	24a. W ai pe 1 • Y		24b. Were prior t	
n of Vital Iding Physician: h. After this certi	To Be	25. Was case referred to medi examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe	Hospital: 1 🗸	Inpatient 2 te of Injury nth, Day Year) 3, 2007	ER/Outpatier 28b. Time of 1900 hrs	nt 3 DO	Other	Vork?	g Home 5 28d. Descr	Residen	ry occurred	her:
Division Spital or Attend tours after death. neral Director:	ë	Accident In 3 Suicide 6 Co	vestigation 28e. Pl ould not be etermined (Specif	ace of Injury - At y) Street					or Tow 3690 Haye	n, State) es Street No	lortheast, W	Rural Route Number, City /ashington, DC.
Divis To the Hospital or A within 24 hours after To the Funeral Divis completely filled in b	Medical	29a. Certifier 1 Certifying one) 2 Medical E 29b. Signature and title of certifying one	Physician: To the back aminer on the base and manner of the base of the back and manner of the back and manner of the back and manner of the back and the back an	is of examination	edge, death occ and/or investig	ation, in my c	ppinion, dea License nur O.C.M.E	th occurred a	at the time, o	29d. D	ce, and due to	o the cause(s) Month, Day, Year)
R (8)		30. Name and address of per Mary G. Ripple MD.	Deputy Chie		aminer 1	11 Penn S	Street, Ba	altimore, M	1D 21201			
Regi		# # 1111 /5 E 17/4/3		A. A.	ORIGIN	AL						

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Medical Certification: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) APR 0 5 2007

29b. Signature and title of certifier



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUMOD,

State

Registrar

60100

University

0

29d. Date signed (Month, Day, Year)

03-30-07

Please Type or Print in Black Indel

ible Ink. Ensure All Copies Are	Legible				
nent of Health and Mental Hygiene		200	7 1	262	7
cate of Death	Reg. No.				
2 Date of	Death		3 Time o	f Death	1

rtermeth bacon		- For State legistrar	or ivial yland / L	Certificate		id Wichtai II	Reg.	ZUU No.	1 1202.
Physiciar	1/.	Decedent's Name (First, Middle, La	st)				Date of Death Month	av Year	3. Time of Death
Medical Examin		Kenneth 4a. Facility Name (if not institution, gi	Bacon		4h City Town o	r Location of Death	April 7, 2007	4c. County of Death	0227 hrs
	;	26000 Point Lookout Roa			Leonardtov			St. Mary's	
Funeral Director			ex 7. Age (I	n yrs. last birthday 24) If Under 1 Ye. Months Day			MM/DD/YYYY) 9. Bir 1983 Foreig Co	thplace (State or In Virginia Juntry)
ńu ż	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
und show a	اج	Maryland St. M	fary's		Leona	rdtown			1 X Yes 2 No
	=	10e. Street and Number 22840 Duke Street	-		10f. Zip Code	20650		. Citizen of What Cou USA	
er death wit , or items 2	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 X Yes 2		Was Decedent of H If Yes, specify Cuba Yes 2 X N	in, Mexican, Puerto		White, etc.	ican Indian, Black, hite
urs afte	핡	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	or Dates:		edent's Usual Occupa	ation (Give kind of v		6b. Kind of Business/	Industry
5 72 hou	ete ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	durin	ng most of working life Fabrica		ired)	Building	8. Cupp 1 v
within giene.	Completed	17. Father's Name (First, Middle, Las	<u> </u>		- Fabilica		e (First, Middle, Ma		a Suppry
215- 215- be filed tral Hy: ked of	Be C	Robert Benjamin						n Lishness	
MD 21215-0036 d.2 should be filed within 7 tith and Mental Hygiene, n. 77 is marked other than tumatic event, the Media.		19a. Informant's Name/Relationship (Debra Jean Lathroum		P.0	D. Box 1002	Leonardto	own, MD 206		
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specif		crematory o	sposition (Name of d or other place) 1emorial Gar	Apr	cil 14,	20c. Location - City or Leonardtown,	
Balti permit. Departir Importi injury o	1	21. Ignature of Funeral Service Lice	× ardin	ev	P.O. Box 2	-Gardiner l 70 Leonard	dtown, MD 2	20650	
Physician		23a. Par I. Enter the disease, or comfailure. List only one cause on e	ach line.	e death. Do not ent	ter the mode of dying	g, such as cardiac c	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Head Injuries Due to (or as a consequ	uence of):					334
		Sequentially list conditions,							
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated	Due to (or as a consequ	ience of):					
cuted nd transit	I Examiner	events resulting in death) Last	Due to (or as a consequ	uence of):					
be exercian a	Medical	UNPENDED	AMENDED					1222	
8760, tificate bung physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	of pregnancy	Fetal death 3	Ectopic pregna	ancy	23d. Date of deliver Month	Ty Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at tin 9 Unknown	ne of death 5	Other (Specify)				
ords, P.O. Box w requires that the death is been signed by the att should be detached for	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in t	the underlying cause	given in Part I.		acco use contribute to 2 ✓ No 3 ☐ Pro	the cause of death? bably 4 Unknown
ds, equires	eted						24a. Was ar		utopsy findings available completion of cause of
ecords ie law requi	Completed						autopsy perform	ned? death?	
tal Rec	a)	25. Was case referred to medical			26.Pla	ce of Death (Check	only one)		
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient					esidence 6 🗸 Othe	er: Scene
ion of tending Pheath.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month Day,Yea Apr 7, 2007	0210 hrs		jury at Work?] Yes 2 ✔ No		involved in collis	sion
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	t be 28e. Place of Injur		street, factory, office	e building, etc	or Town, Sta		dtown, MD
spi hou fil	Medical Ce	4 Homicide 29a, Certifier (Check only one) 2 Medical Examin	cian: To the best of my ler:On the basis of exami	knowledge, death of	occurred at the time, stigation, in my opini-	date and place, and on, death occurred	d due to the cause at the time, date a	(s) and manner as sta nd place, and due to t	ated. he cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signed (M	onth, Day, Year)
900		V n/	1. 16		0.0	C.M.E.		April 7, 2007	
OV OV			Chief Medical Exa	aminer 111	Penn Street, B	altimore, MD 2	1201		
Sta Regist	ate rar	31. Date filed (Month, RD), pear 0	208 32. Registrar's	Signature	Books.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:50 A M Month **Physician** April $1\tilde{0}$ 2007 Earl Vincent Bonds /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**Ճ**M 2□F 58 Yrs. 543-58-5966 October 4, 1948 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notitled at 1 ☐ Yes 2 No Maryland St. Mary's Lexington Park Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19754 20653 Three Notch Road USA Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 Tyes 2√ No Specify: Specify: Black. Baltimore, Maryland 21215-0036 Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Management Assistant h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be tile Department of Heath and Mental Hy, Importent: if item 27 is marked other any injury or other treumatic event, QMCs. 17. Father's Name (First, Middle, Last) Richley Paul Bonds Mary Margaret Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 1516 Unit 33B Lexwood Apartments Lexington Park, MD 20653 Larry Syvester Price / Son Date April 16, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Valley Lee, Maryland St. George's Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P. O. Box 270 Leonardtown, MD 20650 10 Mil 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, minute Immediate Cause (Final disease or condition resulting in death) araial **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death USB 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 Other (specify) 4☐Pregnant at time of death P.O. I the th detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ gig Pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 1 Yes 2DNo 26. Place of Death (Check only one Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 20 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury Hospital or Attending 5 Pending investigation 1 ZNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 - Homicide within 24 hours a To the Funeref I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) ame 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 31, 2007 11:20 PM Υ. Bisnett March Eileen **∜Medical** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 83 Director 507-12-1888 June 06, 1923 Nebraska Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 No Directo Maryland | Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or dical Exa⊞iner must be 303 Adclare Road 20850 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 TxYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ 3 Widowed 4 Divorced 1945 White Be Completed permit. Pages 1 and 2 should be flied within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institutes of Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Schulz Bessie Story ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred L. Bisnett / Spouse 9215 Topeka Street, Bethesda, Maryland 20817-3307 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cemetery 5/9/2007 Arlington, Virginia 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee Brock enden 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Heart Disease /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of death certificate be executed burial-transit Diabetes Mellitus and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐XNo Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47330 04/02/2007 Womes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. Edmonston Drive, #207, Rockville, Maryland 20852 Thomas V. Joseph, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State APR 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 12530 Certificate of Death 1- For State

Physicia	1 1. Decedent's Name (First, Wildlie, Last) Unery Lynn Nichols-Bowen Month Day Year												3. Time of Death 1707 hrs
ledical Examir		4a. Facility Name (if not institution			50WCI		o. City, Town, o	r I ocation o		April 9, 20	4c. County	of Death	
		4520 Windy Hill Road		aniber)			Trappe				Talbot		
Funeral	T	5. Social Security Number	6. S ex	7. Age (In yrs.	last birtho	day)	If Under 1 Yea		r 24Hrs. Min.	8. Date of Bi	rth(MM/DD/YYYY	9. Birt Foreigi	hplace (State or
Director		214–88–2752	1M 2XF	44	4	Yrs.	Months Day	ys Hours	IVIII I.	09/0	8/1962		intry) MD
ž.	F	Usual Residence of Decedent 10a. State 10b. County		Inc. Cit	y, Town o	r Locatio	on .						10d. Inside City Limits
ow any		MD Tall	hot	100.01	,,		rappe						1 Yes 2 No
daryland 28a-f show	Director	10e. Street and Number		l			10f. Zip Code			<u> </u>	10g. Citizen of W		itry?
the Ma		4520 Windy Hi	ll Road				21	673				ISA —	
ms 23.	Funeral	11. Marital Status	Armed	cedent Ever in	U.S.	13. Was	Decedent of H es, specify Cuba	ispanic Orig	jin? (Spe Puerto R	cify Yes or No Rican, etc.)		- Americ e, etc.	can Indian, 8lack,
r death	핍		larried 1 Yes Vorced If Yes, Give Ye	2X No			Yes 2 X N				Specify:	V	√hite
rs afte ural",	ā	3 X Widowed 4 Div 15. Decedent's Education (Spe	or Dates:		16a. D	ecedent	's Usual Occupa	ation (Give I	kind of wo	ork done	16b. Kind of Bu	ısiness/l	ndustry
72 hou	etec	Elementary/Secondary (0-12)		1-4 or 5+)	di	uring mo	ost of working lift Landsc		use retire	ed)	Self	_Fmr	oloyed
5-0036 iled within 7 Hygiene. I other than	Completed	12			_i		Landsc	-	l - N /	Tiret Baidelle	Maiden Surname		
15-0 filed v al Hygi ed othe	Be Co	17. Father's Name (First, Middle William S. Ch	aiffre					Nor	ma H	. Mais	el	•1	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ToB	19a. Informant's Name/Relations Norma H. Chai	ship (Type, Print) ffre/Moth	er	19b.	Mailing	Address (Stre	et and Num	nberorRu	ural Route Nu nnapol	imber, City or Tov	vn, State 214(
and 2 sho tealth and tem 27 is traumati	ı	20a. Method of Disposition		201	o. Place of	f Disposi	tion (Name of c			Date r. 16,	20c. Location		
Baltimore, permit. Pages I at Department of He Important: If ite		1 Burial 2 X Crematio		from State			er place) ematory			007	Balti	more	e, MD
altin mit. P partme portar ury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Fun											uneral Home
m FP Fig		Momis	AlCa			1/195	COVE	≀itchi	P HW	v. Sev	rerna Pai	ck. (MD 21146 Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.					y, such as c	al diac of	respiratory di	TOSE, SHOOK, STA		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		ic and co a consequence		into	xication						
	Ŀ	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	e of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to /or co	a consequence	3 Of):								
ited d ansit	Exa	events resulting in death) Last	d.	a consequence	5 01).								
68760, errificate be executed iding physician and ee as the burial - transit	ian/Medical	X UNPENDED		a. 27. 28a-	f. nei	rME.e	867 , 5/10/	′07 TT					
68760, certificate be ex dring physician	/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes	s, outcome of pr	egnancy				ic pregnar	ncv	23d. Date of Month		y Day Year
68 certif nding	cian	past 12 months?	4 Pres	gnant at time of	death 5	Fe Ot			io progridi				•
Box e death the atter ed for u	Physici	1 Yes 2 No 9 🗸 Ui	nknown 9 Unk	nown				a minera in D	lort I	23e Did	tobacco use con	tribute to	the cause of death?
Division of Vital Records, P.O. Box 6 spital or Attending Physician: The law requires that the death cer norsal Director: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	þ	Part II. Other significant cond	litions contributing	to death but no	ot resulting	g in the L	inderlying causi	e given in F	art i.				bably 4 🗸 Unknown
ords, w require is been si should b	Completed									24a. Wa aut	as an 24b.	prior to	utopsy findings available completion of cause of
ecol ne law te has l	ldmo		· · · · · · · · · · · · · · · · · · ·							per 1 🗸 Yes	formed? s 2 No	death?	es 2 No
tal Rec cian: The certificate ector, page	Be Co	25. Was case referred to medic					26.Pla	oce of Death			-1		
Vita Physicia r this co	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2		utpatient Time of		Other ₄		g Home 5	Residence 6		er: Scene
n of iding Pl h. : After e funera	on:	27. Manner of Death 1 Natural 5 Pe	nding -	ite of Injury nth, Day,Year)			1 1	Yes 2 X		unk			
Division of Vital Rec spiral or Attending Physician: The I nours after death. neral Director: After this certificate! rillled in by the funeral director, page	Certification:	2 Accident Inv	vestigation FING	4/9/2007 ace of Injury - A		<u>d 5:0</u> arm, stre)/ pm] et, factory, offic	e building, e	etc.	28f. Location	(Street and Num	ber or R	ural Route Number, City
Div spital or nours afte neral Dir	ertif		termined (Specia	fy) found	l in r	eside	ence			4520 W	, State) Lndy Hill 1	Rd. T	rappe, MD
bor ne r	lo	29a Certifier	Di dalam Taribah	and of my know	dodao do	oth occu	rred at the time	date and o	lace and	I due to the ca	ause(s) and mann	er as sta	ited.

4-20-07- Up msg. Por F.H. ee: #1

determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number O.C.M.E.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

April 10, 2007

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) APR 1 6 2007 State Registrar

29b. Signature and title of certifier

29a. Certifier (Check only one)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year 3 2007 11:07 A M Lola Bolen April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 22, May 22, Frederick Memorial Hospital Frederick 5. Social Security Number 9. Birthplace (State or Foreign Country) Missouri 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 495-34-7482 74 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☑ Yes 2 ☐ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be n 30 North Place 21701 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s mix; if item traumatic event, the Medical Examiner must ny or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Hamlin Ollie Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 147; Frederick, MD 21705 Jody Carter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 5 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 Donation 5 Dother (Specify) Resthaven Crematory 2007 Frederick, Maryland 21. Signature of Fundament Ce Ligari e Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 nications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to infinitely active cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 12 No page Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital 1 1. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

DHMH 17 Rev 1/2001

State Registrar

Medical

(Check only one)

29b. Signature and litle of certifie

30. Name and arress of person in

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

mple ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 0.7 Day 10 **Physician** 04 2340 Sr. Cannon Paul David /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY **CUMBERLAND** WMHS-BRADDOCK CAMPUS 8. Date of Birth (Month, Day, Year) Sep 2, 1925 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours 1□M 2□F 81 Director 219-14-7449 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Green Spring Hampshire 1 ☐Yes ¥2 ☐ No WV Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 26722 P.O. Box 101D Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married Ž☐ Married 1 □ Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) church minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Offaral Yost Cannon Day William Martin Cannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 101D Green Spring WV 26722 19a. Informant's Name/Relationship (Type. Print) Emma Cannon wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. Date 20c. Location - City or Town, State 20a. Method of Disposition MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/2007 Cresaptown 4 Donation 5 Dother (Specify) 21. Signature of Funeral Arvice License 22. Name Scarpelli Purieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due (or as a cons q, ence of): Sequentially list conditions, it any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as 1 IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 1 ☐ 1 24a Was an autopsy performed? Yes 2 No page 2 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only oge) Be Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 3 00A 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Box 68760% pe P.O. I Division or Vital Records, funeral director, To the Hospital or Attending Ph within 24 hours arer death.

To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

3 ☐ Suicide

29a. Certifier

Medical

State Registrar 4 🗀 Homicide

(Check only one)

29c. License number WW 15226 29d. Date signed (Month, Day, Year) O

30. Name and a press of person who completed cause of death (Item 23a) (Type, Print)

MO SOE HAHN

Day, Year) R19

3. Registrar's Signature

Sunrisc

			For State Registrar	State of Maryla		artment of H			ene 007	12633
	Physicia	an	Decedent's Name (First, Middle, Last,		`ua latua a			2. Date of Death Apr 14,		3. Time of Death 9:45 pm M
	/Medic	al	Vallie Lt 4a. Facility Name (If not institution, give		rabtree	4b. City, Town, or	Location of Death		4c. County of Deat	<u>-</u>
			Beverly Living Cen			Cumber If Under 1 Year	land If Under 24 Hrs.	8. Date of Birth	Allegany	polone (Chata as Envaion
ı	Funeral Director		5. Social Security Number 6. Sec 1214-05-9127	M 2 XF 7. Age (in yrs	. last birthday) Yrs.	Months Days	Hours Min.	May 24,	1910 "5"	hplace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	a-f ehc	ctor	MD Allegan	У	Cumb	perland				1 X Yes 2 □ No
	with the a or 28 be no	Funeral Director	10e. Street and Number 220 Somerville Ave	enue		10f. Zip Code	21502	10	g. Citizen of What Co USA	untry?
	death	nera	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or Items 23s or 28s-f ehow ent, the Medical Examinant be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: wh	-
20	72 hou	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	tking	6b. Kind of Business/	Industry
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ant Cook	1)	A	llegany Co	. Infirmary
and	ld be filed ental Hyg ked other Ic event,	To Be C	17. Father's Name (First, Middle, Last) John H. Orndoff					ne <i>(First, Middle, M.</i> Ellen (Rin	aiden Sumame) nker) Orndo	off
Mary	nd 2 should lith and Mer 27 te marke r treumatic	-	19a. Informant's Name/Relationship (7) Sharon Porter	daughter daughter	19b Mailir P.O.	BOX 122	and Number or Ru	Flintsto	City or Town, State.	D°21530
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hyglene. Importants if item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examination in all the collished at DDCs.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State Ro	Place of Dispo cemerary crer SE HIII Co	sition (Name of natory or other place emetery	ce)	2.0	Oc. Location - City or Cumberlar	
Balti	permit. Departmit. Importa eny inju		21. Signature of Funeral Service Licens	Land	22	^{2. Nam} Scafpel 108 Virg			and, MD 2150)2
	Physician		23a. Part1. Enter the disease, or comb shock, or heart failure. List enter Immediate Cause (Final disease or condition resulting in death)	lications that callised the decine cause on each line.	ath. Do not ent	er the mode of dyin		or respiratory arres		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a conse	equence of):					
7	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):			,		
8760, 🗵	icate be executed physicien and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a conse	equence of):					
9	ertificati ing phy e as the	Medi	IF FEMALE:	23c. If yes, outcome of preg	nancy					
.O. Box	that the dear certificate be executed ted by the attending physicien and detached to use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of de Month	Day Year
Ω.	quires that n signed b uld be deta	ed by Pr	Part II. Other significant conditions co	intributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
Division of Vital Records,	The law requires that ate has been signed b page 2 should be deta	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of 2000
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		oth oth	000 4	ath (Check only one		
n of	ing Phys ifter this ineral di	on: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 ☐ Inpatient 21 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c Injur	y at k?	fome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spe w injury occurred	cify)
ivisio	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str		Yes 2 □ No	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
נ	To the Hospital within 24 hours e To the Funeral Completely filled in		(Check only 2 Medical Exam	/sician: To the best of my ki						
	othe Hathin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	7	29c. Licens			d. Date signed (Moni	
	⊬≯⊢ŏ			n Kly	-112	a Da	2540°	H D	April 16	7007
	5		30. Name and address of person who of	completed cause of death (It	em 23a) (Type	Print)	H.D.:	10/010	m	21500
	Sta	ate	31. Date filed (Month, Day, Year) APR 1 9 2007	32. Registrar's Sig	nature	les de la constante de la cons	my)	····	<u>-) </u>	SILLA_
	Regist	rar	APR 1 9 2007	ARREST SO	200					

07-02571 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day April 4, 2007 1608 hrs Medical Examiner Ethan Andrew Chewning 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 39440 Sunnyside Road Clements 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Maryland Country) September 13. Months Days Hours Director 218-29-8907 1 X M 2 F Yrs 1990 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland St. Mary's Chaptico or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36770 Manor Road 20621 IISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes White imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", on Widowed Divorced If Yes, Give Year Yes 2 X No specify: ð 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) High School Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Ray Chewning, Sr. Sandra Kaye Quade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ P.O. Box 464 Chaptico, MD 20621 Sandra Kaye Chewning / Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery April 9. 20c. Location - City or Town, State timore, 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metropolitan Crematory 2007 Alexandria, Virginia Donation 5 Other Specify 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Mardical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed g physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene DOA ER/Outpatient 3 1 🗸 Yes Na 28a. Date of Injury (Month Day, Year) Apr 4, 2007 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Occupant auto auto collision 1601 hrs Natural 1 Yes 2 V No Pendina 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 39440 Sunnyside Road, Clements, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier (Check only Certifying Physician: To the best of prophosologie, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner; On the basis of examingation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signat

Assistant Medical Examiner Susan Hogan MD 31. Date filed (Month, Day, Year) APR 1 0

30. Name and address of person who completed cause of death (Item 23a)

2007

egistrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 5, 2007

State

Registrar

			For State Registrar	State of Maryland /		rtment of He			iene	7	12635
Р	hysici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	Year	3. Time of Death
	/Medic	al	MARGARET	PURCELL	CAS	HELL			3 200	7	12:00 P M
E	xamin	er	4a. Facility Name (If not institution, give str FRIENDS NURSING			4b. City, Town, or Lo	SPRING		4c. County of		V
Fu	ineral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year I	f Under 24 Hrs.	8. Date of Birth	MONTGO		place (State or Foreign
	ector		214-30-3300	1 2 🗷 F 92	Yrs.	Months Days	Hours Min.	(Month, Day, June 18	1914	Mai	ryland
land	t t	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tox	wn or Loc	ation					10d. fnside City Limits
Mary	If she	tor	Md. Montgome		okev						1 □Yes 2 🗷 No
death with the Maryland	or 288	Director	10e. Street and Number			10f. Zip Code		11	Og. Citizen of W	hat Cou	ntry?
ath wi	unit b	raic	22100 New Hampshir	e Avenue			20833		United	Sta	ates
21215-0036 d within 72 hours after de giene.	"natural", or items 23a or 28a-f show alical Evar about must be collised at	by Funerai	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in U.S. Amed Forces? 1		/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2K No		cify Yes or No- Rican, etc.)		, White,	can fndian, etc. nite
5-0 72 h₀	alcal	eted	15. Decedent's Educa (Specify only highest grade of	tion 16a		ent's Usual Occupation		na	16b. Kind of Bus	siness/In	dustry
Mithin Mithin	Then as Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ONOTuse retired) Homemaker		.,9	Own	Uome	
N po	d other than "natur event, the Medical		12 17. Father's Name (First, Middle, Last)	0			3. Mother's Name	(First, Middle, A			.
Maryland d 2 should be file th and Mental Hy		To Be	Ernest V. Puro	ell			Christ				
Taryla 2 should and Men	9 2 €		19a. Informant's Name/Relationship (Type			Address (Street and					
C = 0	item 27 other tr		Barbara C. Charles			O New Hamp					
S C	= 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	IOVALITORII STATE		ition (Name of atory or other place)	1		20c. Location - 0	-	
off. P.	Important: If any injury or once		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Iconspec	Mt. C		1 Cemetery Name and Address		/07	Sunshi	ne,	Maryland
Balt permit. Depart	any onc		X / Charles	m-00470		Muriel H. P. O. Bo	. Barber	Funeral	Home	Md	20882
300	T.B.		23a. Par. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do		r the mode of dying,	such as cardiac o	r respiratory arre	est,	Ma.	Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	RENT	7	GALINE					Onset and Death
	dical niner		resulting in death)	Due to (or as a consequence	,	Mund	South				1 West
		-	Sequentially list conditions, b.	Due to (or as a consequence	HON	ame.	MONIA				LUFFES
nted .	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S De	nve						W. Sales.
o, exec	an an rial-tr		that initiated events c. resulting in death) Last	Due to (or as a consequence	of):					+	turny
876U	physician and the burial-transit	dicai	d.							1	
× ortific	se as I	/Med	IF FEMALE:	16.000							
the death certificate be executed	e attending p	Physician/Me	in the past 12 months?	. If yes, outcome of pregnancy 1□Live birth 2□Fetal deat 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year
1	detached t	Phys	9 Unknown								
OrdS	pe o	þ	Part II. Other significant conditions contri DEMENTA	buting to death but not resulting	in the un	derlying cause given	in Part I.			oute to t	ne cause of death? Dably 4 Munknown
I Ke The la	page 2	Completed						24a. Was ar autops perform 1 Yes 2	neda de	ior to co eath?	psy findings available mpletion of cause of 2 No
OT VITALI Physician: 1	director,	o Be	25. Was case referred to medical examiner?	pital:		Other	6. Place of Death				
		\vdash	27. Manney of Death	28a. Date of Injury 28b.	Time of	3 DOA 28c. Injury at Work?	4 Nursing Hon	ne 5 Reside			(y)
VISION Attending r death.	e fun	atio	1 ☐Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		s 2 🗆 No				
UIVISION Il or Attending after death.	Director: After of in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory, office	2	28f. Location (Str. City or Town	eet and Numbe. State)	r or Rura	al Route Number,
pital c	iled is										
To the Hospital o	completely filled	ledical	one) 2 Medical Examine	ien: To the best of my knowledg '2 On the basis of examination a and manner stated.	je, death nd/or invi	occurred at the time, estigation, in my opini	date and place, a ion, death occurre	and due to the ca	use(s) and man ite and place, ar	ner as s nd due to	tated. the cause(s)
	9 9	Σ	29b. Signature and title of certifier	11		29c. License n			d. Date signed		
5		-	20 Name and address of the	ofeted cause of death (the Co.)	/T: 7		947	/	MRIL 9	4, 2	00/
			30. Name and address of person who com Evelyn Jackson, M			rint) Road, Cla	arksvill	e, Md.	21029		
. ≜ B	Sta legistr	- 21	31. Date filed (Month, Day, Year) APR 0 5 2007	A. Registrar's Signature	4			_,			-
			MI II O D	Transfer of							

			For State Registrar	State o	of Maryland / De C	partment of H ertificate of L			jiene)) 7	12636
			Decedent's Name (First, Midd	lle, Last)				2. Date of Dea		3. Time of Death
	ysicia Medic		Ashleigh Nic	ole Coverd	lale			04 Month	03 2007	06:19 M
1	viedic		4a. Facility Name (If not institution	on, give street and nu	mber)	4b. City, Town, or	Location of Death	1	4c. County of Dea	ath
			Memorial Hosp	ital at Ea	aston	Easton			Talbot	
Fun Dire			5. Social Security Number None	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 1 16	8. Date of Birth (Month, Day 04 03	, Year)	rthplace (State or Foreign country) cyland
	5.51	t	Usual Residence of Decedent				1 10			7 =
Maryland	=		10a. State 10b. Count	у	10c. City, Town or	Location				10d. Inside City Limits
A a :	Sell I	cto	Maryland Dorch	ester	Hurlo	ck				1 ☐ Yes 2 ☐ No
2 ± 2 ×	20)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
23 × 23	1	ral	5016 Mt. Zic				643			USA
vre, Maryland 21215-0036 // () stand 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.	aninerm	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 ☐ Yes	2 XNo ve	 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No 	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036 to 2 shours at the 2 should be filed within 72 hours att and Mental Hygiene. 27 is marked other then "natural", or	9	edt		nt's Education		cedent's Usual Occupa	ation	-	16b. Kind of Busines	s/industry
7. nin 72	Asolic	piet		est grade completed) College ((G	ve kind of work done on DO NOT use retired	during most of wor	rking		,
212 d vit	3	E	0	College (None			None	
Maryland 2121 12 should be filed within h and Mental Hygiene.	vent,	Be Completed	17. Father's Name (First, Middle	, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
vid by Wenta	tlc •	ToE	Phillip Ashley	Coverdal	е		Candic	eM. Schu	yler	
and I	auma auma		19a. Informant's Name/Relation	ship (Type, Print)	19b. Ma	ailing Address (Street a	and Number or Ru	ıral Route Numbe	r, City or Town, State.	Zip Code)
and and a	er tra		Phillip A. Cov	erdale/Fa	the same of the sa		al Road,	and the second second second second	w Market,	
altimore,	r of		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 □Removal from	State cemetery, o	position (Name of rematory or other place		Date	20c. Location - City of	
Pag ment ent: I	o cu		4 Donation 5 Other (East New	Market Cemet	ery 4/7/	2007 E	East New Ma	arket, MD
Baltimor permit. Pages Department of I	any Inj		21. Signatury of Fineral Service	Liferson Sch	ller	22.Name and Addres Zeller Fun 106 Main S	ss of Facility eral Hom treet, E	e, P. O. ast New	Box 207 Market, MI	21631
			23. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the death. Do not					Approximate Interval Between
Physic	cian		Immediate Cause (Final disease or condition	D	rematur	LV				Ons I and Death
/Med	_		resulting in death)	a Due to	(or as a consequence of):	1,1,7				177700
Exam	iner		Constitution for the second second							
	_	ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying	Due to	or as a cons nuence of:					
cuted	burial-transit	Examiner	Cause (Disease or injury that initiated events	с						
0, e exe	urial-l		resulting in death) Last	Due to	(or as a consequence of):					
8760, cate be execu	the b	dicai		d		-				
Box 6 ath certifi	or use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live I	nant at time of death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of d Month	elivery Day Year
P.O. I that the de	tach.	ېر پې								
(A) (B)	should be de	ed by	Part II. Other significant condit	ions contributing to d	leath but not resulting in th	underlying cause give	en in Part I.	23e. Did to	J	to the cause of death? Probably 4 Unknown
aw s	2 sho	pet						24a. Was autop		autopsy findings available completion of cause of
Rec The lav	page	E						perfor	med2 death1	
Vital F siclan: Th	5	0	25. Was case referred to medic	al			26. Place of Dea	ath (Check only o	7	
- S	- <u>ē</u>	To B	examiner? 1 □ Yes 2 No	Hospital:	Inpatient 2 ER/Outpa	tient 3 DOA Othe	er: 4 🗌 Nursing H	lome 5 Resid	lence 6 Other (Sp	ecify)
ng Pt	neral		27. Manner of Death Natural 5 ☐ Pend	28a. Date (Mor	of Injury 28b. Time		/ at k?	28d. Describe h	ow injury occurred	
SiO	he fu	atic	2 Accident inves	tigation		M 1 🗆	Yes 2 □ No			
Division of lor Attending Phy after death. Director: Atter this	in by t	Certification:		mined 288. Place	e of Injury - At home, farm, ling, etc. (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or and State)	Rural Route Number,
pital urs a	Pelli		2is Certifier Certify	to a Physician T. d.		and the second second second	co data and store	and the same		Constitution of
Division o To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After it	letely 1	Medicai		I Eyaminer: Og the b	e best of my knowledge, di pasis of examination and/o nner stated.					
To the	сошр	ž	29b. Signature and title of certif	ør //		29c. License	a number		29d. Date signed (Mo	nth, Day, Year)
			ING /.	UNZ		D5009	94		4/4/0	2
			30. Name and address period						,,,,,	
			Mark S. Langfi		8579 Commerc	e Drive, I	Easton, N	MD 21601		
Re	Sta egistr		31. Date filed (Month, Day, Yea APR	0 6 2007 32. 5	Registar's Signature	Sporte				

			Please	Type or Print				•	•	
		ı.	For State	State of Mar				ntal Hygie	ene	12637
			Registrar		Ce	rtificate of D	Death	Reg	j. No,	1 2 0 0 1
	Physici /Medic		1. Decedent's Name (First, Middle, La	Marie	Cove	rdale		Date of Death Month	Day Yeer	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv	1 1 -	ston	4b. City, Town, or Easton	Location of Death		4c. County of Dea	ıth
	Europal		Mey Monal Hosp 5. Social Security Number 6.5		(In yrs. last birthday)	If Under 1 Year		Date of Birth	lalbot	tholace (State or Foreign
	Funeral Director			□ M 20 X F	Yrs.	Months Days	Hours Min.	(Month, Day,		thplace (State or Foreign ountry)
	land ow		10a. State 10b. County	1	10c. City, Town or Lo	ocation				10d. Inside City Limits
9	he Many 8e-f sh	Funeral Director	Maryland Dorches	ter	Hurlock					1 ☐ Yes 2 No
2	e or 2	Ē	10e. Street and Number 5016 Mt. Zion Ro	ad		10f. Zip Code 2164:	2	109	g. Citizen of What C	•
2	eath	era	11. Marital Status	12. Was Decedent Ev	ver in II S 13		spanic Origin? (Specif	v Ves or No-	USA 14. Race - Am	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 te marked other then "naturel; or Items 23e or 28e-1 show eny injury or other treumatic event, the Medical Examiner must be notified at once.	þ	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:	can, etc.)	Black, Whi	
Õ	2 ho	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion	16	6b. Kind of Business	/industry
21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 le marked other then "n freumatic event, the Med	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give		uring most of working		None	
d 2	filed Hygid ther		17. Father's Name (First, Middle, Last,)	NO		18. Mother's Name (F	First, Middle, Ma	None	
Maryland	d be ental ced o	To Be	Dhillin Adalan	Coverdal	0		Candice	∞	Schou	100
<u>-</u>	Shoul od Me mari	F	19a. Informant's Name/Relation ip (ng Address (Street a	nd Number or Rural F	Route Number, (
	and 2 salth ar		Phillip A. Coverd				Road, Eas			
ē,	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	Date	9 20	Oc. Location - City or	Town, State
Baltimore,	Pages nent of h nnt: If ite ury or o		1 Burial 2 Cremation 3 C 1 Other (Specif		1		ery 4/7/200	07 E.	ast New M	arket. MD
alti	permit. Pag Department Importent: I eny injury o		21. Sign, two of uneral Sergice is ea		22	2. Name and Address	s of Facility			
m	Depar Depar Impo		servered &	Laller	Ze	eller Fune 06 Main St	ral Home, reet, Eas	P. O. j	Box 207 arket, MD	21631
			234. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do not ent					Approximate Interval Between
10	Physician		Immediate Cause (Final disease or condition	PR		ZITY				Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):					177 143
	Examiner		Sequentially list conditions	b						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	and and I-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	be ex	aiE								
687	ficate phys s the			_ d						
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		-			23d. Date of de	livery
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medio	in the past 12 months? 1 Yes 2 No	1□Live birth 2 4□Pregnant at tir 9□Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the	Phy	9 Unknown							
ecords,	sign sign d be	by	Part II. Dther significant conditions	ontributing to death but	not resulting in the u	Inderlying cause give	n in Part I.	1 Yes		o the cause of death? robably 4 □Unknown
000	law requas been 2 should	Completed						24a. Was an autopsy		utopsy findings available completion of cause of
H	eicien: The law certificate has b irector, page 2 s	Com						performe		
of Vital R	Physicien: this certificatal director.	Be (25. Was case referred to medical examiner?				26. Place of Death (0		`	
	Physic this ce al dire	2	1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA Othe	r. 4 Nursing Home	5 Residen	ce 6 ☐Other (Spe	эсіfу)
n o	ding P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	Work'	?	d. Describe how	injury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b				es 2 No			
Division	of or Attence after death I Director:	ertif	4 Homicide determined		y - At home, farm, str (Specify)	reet. factory, office	28f	City or Town,	et and Number or R State)	lural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai Certiflcation;	29a. Certifier (Check only one) 1 Certifying Ph	nysicien: To the best of miner: On the basis of ea and manner state	xamination and/or in	h occurred at the time evestigation, in my opi	e, date and place, and inion, death occurred	d due to the cau at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of centrier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
	_		> 1116 lutte	- m>		Ď500	94		4/4/3	7
			.,	completed cause of dea			-t 3m 0	1.601		
			Mark S. Langfitt,	20 D	- C'		ston, MD 2	1001		
***	Sta Registr		31. Date filed (MonthAPR) 6	2007 32. Histirar	s Signature	grown .				

			1 - For State Registrar	State of Mar		partment of F ertificate of			giene Reg. No. 20	07	12638		
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Las Burton S. Cook	ot)				2. Date of Dea Month April	Day	Year 2007	3. Time of Death 2:00 a M		
,	Examin	_	4a. Facility Name (If not institution, give	·		4b. City, Town, o		ith	4c. County	,			
_			Sunrise Assisted		(loo		apolis If Under 24 Hr	S O Date of Birds	Anne Arundel				
K	Funeral Director		5. Social Security Number 085–12–5676 Usual Residence of Decedent	ex 7. Age ((In yrs. last birthda 85 Yrs.	Months Days	Hours Mir		/ Year)	9. Birthpla Counti New	ace (State or Foreign ry) York		
	/land	}	10a. State 10b. County		I0c. City, Town or	Location				10	d. Inside City Limits		
	a-f sh	cto	FL Mario	n	Ocala						1 ¥Yes 2 No		
	h with the	al Director	10e. Street and Number 2170 NE 43rd Str	eet		10f. Zip Code	4479		10g. Citizen of	What Count	ry?		
	ems a	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1:	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify Yes or No-	14. Rad	ce - America			
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1944 - 1952	1 ☐ Yes 2 反 No		nto riicari, etc.)		fy: Whit			
ה ה	72 hc 'natuı	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retire	oation during most of w	orking	16b. Kind of B	Business/Indo	ustry		
7	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire . Enginee	*		ות	ectror	nice		
7	filed v Hygie ther t		17. Father's Name (First, Middle, Last)			шідпісе		ame (First, Middle,			1105		
ylanı	nould be in Mental in arked or natic eve	To Be	William Cook				Pearl	Musson					
, Mar	and 2 st ealth and n 27 is n ner traun		19a. Informant's Name/Relationship (*Richard Cook/Son		6	ailing Address <i>(Street</i> 566 White	Swan Dri	ve Arı	nold, M	D 2101	12		
5	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	l .	position (Name of rematory or other pla	, ,,,,,,,	ril 3,	20c. Location	•			
allillor	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify		Metro	Crematory	1 21	07	Balti	more,	MD		
0	permi Depar Impo any Ir		21. Signature of Funeral Service Licer	See Similar		Barranco 495 Gov.		P.A. Sev	verna P	ark Fu	neral Home D 21146		
	Physician /Medical Examiner	_	23a. Part1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a ob.	consequence of):		ng, such as cardi				Approximate Interval Between Onset and Death		
_	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):								
,00/00	cate be executed physician and the burial-transit	dical Examiner	that initiated events ' resulting in death) Last	Due to (or as a d	consequence of):								
O. BOX C	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal death	3□Ectopic pregnanc 5□ Other (specify) _	у			ate of deliver	ry Day Year		
Ĺ	s that ned b	by Pr	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use con	ntribute to the	e cause of death?		
colds,	equire en sig ould b		tallire	to pri	ll			1 🗆 Y	res 2□ No	3 Proba	ably 4 Onknown		
בי	The law re te has be age 2 sho	Completed	Denell	zia					rmed?	prior to com death?	osy findings available apletion of cause of		
[D	ian: rtifica stor, p	BeC	25. Was case referred to medical examiner?				26. Place of D	1∐ Yes eath (Check only o		/	. 1		
>	hysic his ce I direc	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ient 3 DOA Oth	ner: 4 🗌 Nursing	Home 5 ☐ Resid	dence 6.20th	her (Specify,	155-/10LP		
5	ath. ath. r: After the funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wo	ryat rk? ∣Yes 2 ∐ No	28d. Describe h	now injury occur	rred			
	al or Atte s after des il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.	/ - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 secompletely filled in by the funeral director, page 2.	ledical C		ysician: To the best of niner: On the basis of e and manner state	xamination and/or								
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, E	Day, Year)		
	\		· // -			D5	1028		4-2	2-07			
	6,		30. Name and address of person who Actitya Chopya	MD 600	Kidgel	ve, Prilit)	231 Ar	mapolis	am c	214	0		
	Sta	to	31. Date filed (Month, Day, Year)	32. Pegistrar	s Signatur	10		1					

State Registrar

APR 0 4 2007

ary Clayton Ch	1	etate of maryland, Bopan	tment of <i>ificate of</i>		Mental I		eg. No.	2007	12539
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last) Gary Clayton Chastain				2. Date of Deat Month April 11, 2		Year	3. Time of Death 1318 hrs
)		4a. Facility Name (if not institution, give street and number) 12 Holly Road	4	b. City, Town, or L Pasadena	ocation of Dea		4c. Coi	unty of Death Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24H Hours M		th (MM/DD/)	(YYY) 9. Birth	nplace (State or ntry) Florida
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location	on	<u> </u>				10d Inside City Limits
yland a-f show	ğ	Maryland Anne Arundel 10e. Street and Number		10f. Zip Code	Pasa		Og Citizen	of What Coun	1 Yes 2 X No
with the Maryland ms 23a or 28a-f show any be notified at once,	Dire	12 Holly Road			21122			U.S.A.	
r death or ited	Fune	11. Marital Status 1 X Never Married 2 Married 1 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	If Ye	s Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Puer	Specify Yes or No to Rican, etc.)		White, etc.	an Indian, 8lack, uite
nours aft natural" Xamine	ed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent	's Usual Occupationst of working life	on (Give kind o			of Business/Ir	
5-0036 led within 72 hours afte Hygiene. tother than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	•	lice Offi		·	Law	Enforc	ement
라 를 찾을 때	Be Cor	17. Father's Name (First, Middle, Last) Alfred E. Chastain, Sr.		1		me (First, Middle, Medac)		name)	
MD 2121 id 2 should be fil ilth and Mental I m 27 is marked aumatic event,		19a. Informant's Name/Relationship (Type, Print) Alva Chastain/sister-in-law				or Rural Route Nun			Zip Code) 401
Irnore, MD 2 Pages 1 and 2 shoument of Health and I lann: If item 27 is ror or other traumatic		1 Burial 2 X Cremation 3 Removal from State	ematory or oth	tion (Name of cemer place) • Cremato		Date 13/2007		ition - City or	
Baltimore, permit. Pages I an Department of Hea Important: If iten		4 Donation 5 Other Specify: 21. Sign uneral Price Licensee	22. N	ame and Address	of Facility J	ohn M. Ta	aylor	Funera	
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.							Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (morr hine of): Due to (or as a consequence of):		vcodone) ii	ntoxicat	lon			Death
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	:						
ed Sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	:						
iO, e be executed ysician and burial - transit	Medical E	X UNPENDED ##5NDED7,28a-f, per	rME . 286	7. 5/15/07	TT				
8760, tificate be ng physical as the buri	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the	ancy	tal death 3	Ectopic preg	gnancy	23d. Da Mor	ate of delivery	ay Year
Box 6876 death certificate the attending phy	ysician/	1 Yes 2 No 9 Unknown 9 Unknown	th	ner (Specify)					
P.O. Best hat the digned by the	by Phy	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.				he cause of death? ably 4 Unknown
Division of Vital Records, rad or Attending Physician: The law require is after dealing. The law require all Director: After this certificate has been signed in by the funeral director, page 2 should b	Completed					24a. Was autop			opsy findings available ompletion of cause of
tal Rec		25. Was case referred to medical		26.Place	of Death (Che	1 🗸 Yes		1 🗸 Ye	s 2 No
f Vita Physicia or this ce ral direct	To Be	TV Yes 2 No	ER/Outpatient 28b. Time of I		Other Nur	sing Home 5		6 Other	Scene
ion of tending Pheath	ition:	1 Natural 5 Pending Fnd //11/2007	unk		es 2 X No	unk	now injury c	ocurred	
Divisi al or Ati s after de al Direct ed in by	Certification:	3 Suicide 6 Could not be determined (Specify) found a		et, factory, office bi	uilding, etc.	28f. Location (or Town, S 12 Holly			ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	29a Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination an	je, death occur			and due to the cau	se(s) and m	anner as state	ed.
To wit	Med	29b. Signature and title of certifier		29c. License					nth, Day, Year)
		Theodore Mr The This 30. Name and address of person who completed cause of death (Item 2	<u>1113</u>	O.C.M	/1. □.		April 1.	2, 2007	
8		Theodore M. King, Jr., MD. Assistant Medical E.	xaminer	111 Penn Str	eet, Baltim	ore, MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 6 2007 32. Physistran's Signatur	& So	ark		 			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14706 McGill Drive Cumberland Allegany Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth May 6, 1925 1 M 2 XF 215-20-7363 81 Usual Residence of Decedent 10c. City, Town or Location Cumberland 10d. Inside City Limits Allegany MD 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14706 McGill Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2XNo 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) secretary Tire Company 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Peter Joseph Narey Veronica Anne Cullen Narey 199 4708 McGill Brive and Number or Rural Route Number, City or Town, State 70 Code 1502 19a. Informant's Name/Relationship (Type, Print) Maureen Blanco daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cemetery 4/17/2007 Frostburg MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugueral Service Licenses 22. Nam Scarpellis Fürreral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval P 23a: Part1. Enter the disease, or complice shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac terval Between set and Death fmmediate Cause (Final disease or condition resulting in death) Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a cons

Physician /Medical Examiner ed by the ettending physicien and deteched for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

by Physician/Medical Examiner Be Completed within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. Certification: Medical

Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	•	,	
fF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions for		underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown
Hyperte	Msim; Hyr	en chelestere	24a. Was an autopsy performed 1 Yes 2 🖺	
25. Was case referred to medical examiner?			eath (Check only_one)	
1- Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 esidence	e 6 ☐Other (Specify)
27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how i	njury occurred
3 Suicide 6 Could not be determined	28e. Place of fnjury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rural Route Number, tate)
29a. Certifier 1 Certifying Physical Check only one)	ician: To the best of my knowledge, dea ler: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number		Date siggled (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)



ath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dorota Duchnowski

-,	194		1	1	1	jm	1
1	11		- 2	1	1	-7	[1
-		1	- 1	1	l-mp	w	1

		1- For State Certificate of Registrar Certificate of		Reg. N	2001 10.	14041
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exam	iner	DOROTA DUCHNOWSKI 4a Facility Name (if not institution, give street and number) 44	b. City, Town, or Location of Dea	Month Da April 13, 2007	4c. County of Death	0011 hrs
		Johns Hopkins Hospital	Baltimore	uri	46. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 0 9 6 - 7 4 - 4 0 2 7 1 M 2 XF 4 4 Yrs.	If Under 1 Year If Under 24H Months Days Hours Mi		M/DD/YYYY) 9. Birth Foreign 1962 Cou	
		Usual Residence of Decedent			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, = 0 = 4 = 4
v any		10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
Maryland 28a-f show any d at once.	tor	MD Cecil Ceciltor		140		1 X Yes 2 No
h the Mary 3a or 28a otified at	Director	10e. Street and Number 200 Ariel Ave.	10f. Zip Code 21913	U	Citizen of What Coun	
death wit or items 2 must be m	Funeral	1 Never Married 2 Married Armed Forces? If Ye 1 Yes 2 X No	Decedent of Hispanic Origin? () is, specify Cuban, Mexican, Puer		14. Race - Americ White, etc.	
s after ral",	by F	or Dates:	Yes 2 X No specify:	Front days 400	Specify W.T. b. Kind of Business/Ir	nite
2 hour "natu	ted		's Usual Occupation (Give kind o est of working life. DO NOT use re		D, KING OF BUSINESS/II	ladstry
21215-0036 und be filed within 7: Mental Hygiene. marked other than ic event, the Medical	ompleted	3 Seci	retary	ne (First, Middle, Maid	utomobil	e Sales
215- be filed ntal Hyg rked otl	Be C	17. Father's Name (First, Middle, Last) Ian Wasilewska		ja Turch		
MD 21 12 should th and Mer 17 is man umatic ev	٦	Janusz Duchnowski (husband) 200		cecilton,	MD. 219	13
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturalt", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Thursday Commercial	tion (Name of cemetery, er place) Cemetery 4/		Galena,	
Baltir permit l Departme		21 Signature orduneral Service Libersee Ga. M.0.0.5.1.0. 11.8	ame and Address of Facility Lena Funeral B West Cross	Home of	Stephen	L. Schaec
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Caus- (Final disease or condition resulting in death) a Complications of Gastric a Due to (or as a consequence of):	and Biliary Outlet	Obstruction		Death
		Adhesions				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
\	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last used to (or as a consequence of):				
and - transit		d. Pancreatic Cancer				
be exection a sician a urial - 1	Medical	X UNPENDED AMENDED d,27, perME, g866,	4/21/07 TT			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - tra		past 12 months?	al death 3 Ectopic preg		23d. Date of delivery Month D	ay Year
Box e death the atte	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown				
(ecords, P.O. Ihe law requires that the are been signed by the age 2 should be detached.	<u>۾</u> ا	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to t	
Division of Vital Records, ral or Attending Physician: The law require is after death. Director: After this certificate has been sited in by the funeral director, page 2 should the	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
Recc The lay cate ha	l mo			performe 1 V Yes 2	d? death? No 1 ✓ Ye	s 2 No
tal Fiant:	Be C	25. Was case referred to medical examiner?	26.Place of Death (Chec			
F Vid Physic rr this	2	1 Yes 2 No Inpatient 2 ER/Outpatient		sing Home 5 Res	sidence 6 Other	:
n of viding Ph	ü	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 Yes 2 No	Zod. Booding flow	mjary occarred	
/iSior r Attend ter death irector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	t, factory, office building, etc.			ral Route Number, City
Divi pital or ours afte eral Dir	erti	4 Homicide determined (Specify)		or Town, State	*)	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical (29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurr (Check only ✓ Medical Examiner: On the basis of examination and/or investigation.	red at the time, date and place, a ion, in my opinion, death occurred	nd due to the cause(s d at the time, date and) and manner as state I place, and due to the	ed. e cause(s)
To To Com	Med	and manner stated 29b. Signature and title of certifier	29c. License number		9d Date signed (Mor	
		Chrol Haller	O.C.M.E.	A	pril 13, 2007	
d		30. Name and address of person who completed cause of death (Item 23a)	New - A Dalking A4D 040	204		
- Q		Company of the Compan	Street, Baltimore, MD 212	:01		
Regis	tate	N DD 3 D 71111/ EDVANZAGO JE AT				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 ď7' **Physician** 01 7:45 pm Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 2215 Herring Creek Drive Accokeek Prince Georges If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yo 3/26/32 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Months 1 □ M 2 🗓 F Carolina 577-50-7586 75 Director Usual Residence of Decedent the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or frame 23s or 28s-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ➡ No Completed by Funeral Director Prince Georges Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mantei Hygiena. Int: If Itam 27 is marked other than "natural", or frems 23a or 20735 5305 Vienna Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Domestic 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Alice McCrae John Wesley McNeil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If Itam 27 is any injury or other training. Mary Davis/daughter 2215 Herring Creek Dr. Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition South Burial 2 Cremation 3 Removal from State Dillon, Carolina Hamilton Cemetery 4/7/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Washington, DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiomyopathy Examiner Due to (or as a consequence of) Physician/Medicai Examine Cardiac Arrhythmia anding physician end use es the bunel-transit or Attanding Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Cerebrovascular Disease Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Diabetes Mellitus, II Hypertension 1 YUS 25100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Au thter 1 ☐ Yes 2 → No this After this funaral o 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled in 29a. Certifier 1🔂 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D28079 4/4/07 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Francine Higgs-Shipman 9200 Basil Court, suite 200 Largo, MD 20774 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 16 Rev 6/95

Registrar

APR 0-5-2007

Carlos Diego Danforth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 | 2643

State of Maryland /	Department of	of Health	n and N	Mental I	Hygiene

	1- For State Certificate of Death Reg. No.																	
Physician/		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Pay Vegs										3	B. Time of Deat	th				
**adical Examine		CARLOS	DIEG	DA C	NFOR	$\mathbf{T}\mathbf{H}$							Month April 3, 20	Day 07	Year		1517 hrs	
		a. Facility Name (if	not institution	n, give st	eet and nu	imber)		4	b. City. T	own, or L	ocation o		4c. County of Death					
		16700 Barns		-					Boyds						Iontgome			
Funeral	5	Social Security N		6. Sex		7 Age (In	yrs. last birt	thdav)		r 1 Year	If Under	24Hrs	8. Date of Birt	h (MM/	DD/YYYY	9. Birth	place (State or	
Funeral Director		214-75-		,		1		iliday)	Months	_	Hours		MARCH		200	oreign		
Director	L			1 X M	2F	'		Yrs.								Cour	ntry) MD	
	_	Isual Residence of					0.1									- 1	0d. Inside City	(Limite
w any	1		10b. County			10c	. City, Town		PT1									
and show	5	MD	MON	TGOM	IERY		BOY	DS									1 Yes 2	Mo No
ne Maryland or 28a-f show fied at once.	1 2	0e. Street and Nur	nber						10f. Zip				10g. Citizen of What Country?					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commission by Filmeral Director	5	16700	BARNE	SVII	LE R	ROAD				2084	11				US	A		
s 238		Marital Status		T1:	2. Was Dec	edent Eve	r in U.S.	13. Was	Deceder	nt of Hisp	anic Orig	in? (Spec	ify Yes or No-		14. Race - /	America	an Indian, Blac	k,
r death with or items 23 must be no	<u>₽</u> :	Never Marrie	ed 2 M	arried	Armed F			If Ye	s, specify	Cuban,	Mexican,	Puerto Ri	can, etc.)		White,	etc.		
er de		3 Widowed	4 Div	orced If Y	Yes es, Give Yea	2 X	No	11	Yes 2	No	specify:	MEXI	CAN		Specify:	WI	HITE	
rs aft	<u>-</u> ا⊇	15. Decedent's Ed		or	Dates:		ed) 16a	Decedent							Kind of Busin			
hour mate	<u> </u>	Elementary/Seco			College (during mo									•	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	2	0	induity (0 12)		oonege (, , 0, 0 - ,												
with with Mer t	$\frac{1}{5}$	7. Father's Name (Cient Middle	Loct)						1 1:	8 Mother's	Name /F	irst, Middle, N	//aiden	Surname)			
Hygel Hygel										- ["			ANN DA					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		GERARD			Deiest \		140	h Mailing	Addroos	/Chront			al Route Num			State	Zin Code)	
shoul nd M		CAROL D				ZR							RD., E					
MD at 2 short and 2 short and 2 short and 27 is aumatin					10 2 112		20b. Place						Date		Location - C			
F. F. F. F. F. F. F. F. F. F. F. F. F. F		0a. Method of Disp		3 🗆	Removal fr		cremat MONO	tory or oth	er place)	e oi ceiii		4/7/		1	EALLS			1D
Page ent o		4 Donation 5					MONO	EMET	ERY			ユ / //	0 /] B.	PALL	V Т.	, r	10
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be not To Re Completed by Filmeral I	_	1. Signature of Fu						22. Na	me and.		of Facility							
B P P III		W	1. De	U				HI	LTO	N Er	JŅĒK	ALL	IOME RNESVI	т.т.	т мт	2	0838	
Physician	- 2	3a. Part I. Enter th	e disease, or	complica	tions that c	aused the	death. Do n	ot enter th	e mode o	f dying, s	such as ca	ardiac or re	espiratory arre	est, sho	ock, or heart		Approximate	
/Medical	10	failure. List onl	•													l	Between Ons Death	
Examiner		mmediate Cause (i or condition resultir		_	nging to (or as a	conseque	nce of):			_						\neg		
				h	10 (01 00 0	a conceque	1100 017.											
ă	5 i	Sequentially list cor f any, leading to im		Due	to (or as a	a conseque	ence of):											
====		cause. Enter Unde		C														
ted Insit	Na.	events resulting in		Due	to (or as a	conseque	ence of):											
ecute and tran	ĕ⊢			¬ <u>ď</u> .—														
760, freate be executed g physician and s the burial - transit	3	UNPENDED			MENDED													
3760 ficate g phys s the bu	<u> </u>	F FEMALE:					f pregnancy							23	d. Date of de			
~ ~ ⊕ ∞ ~ C		3b. Was decedent past 12 months			D	birth		2 Fet			Ectopic	pregnanc	У		Month	Da	ıy Y∈	ear
Box 68760, e death certificate be the attending physiced for use as the but but etc.	2	1 Yes 2	1 0 9 Ur	lun neven		nant at time	eorgeaun	5 Oth	er (Spec	ify)				ł				
	Ë -				9 Unkn						was in Da	-	23e Did to	hacco	use contribu	ite to th	ne cause of dea	ath?
	<u>-</u>	Part II. Other signi	ncant condi	tions co	ntributing t	o death bu	t not resultir	ig in the u	idenying	cause gi	veninra	141.					bly 4 Uni	
ires i	<u> </u>																	
required been should	Completed												24a. Was autop				ppsy findings a mpletion of ca	
e law	티												perfo	rmed?		ath? ✔ Yes	2	No
A i i i i i i i i i i i i i i i i i i i		25. Was case refer	rad to madia	1 1 1						6 Place	of Death	Check on				, 100		-
cert rector	ן מֿ	examiner?	rea to medica		pital:	Inpatient	2 ED/C	Outpatient			241			Reside	ence 6 🗸	Other:	Scene	
Phys	<u> </u>	1 Yes 27. Manner of Deat	2 No			of Injury		Time of Ir			y at Work		8d. Describe					
Affer fune	<u>ا ۾</u>	1 Natural		dia a	FOUNT	h, Day,Year)		UND:	,,,		es 2	l⊢	anged by	fathe	r			
ttene theath the	ਭੂ	2 Accident		iding estigation	Apr 3, 2			7 hrs									I Donata March	Cit.
or A Direction of the property	≅	3 Suicide		ld not be	28e. Plac	ce of Injury	- At home, f	farm, stree	t, factory	office bu	uilding, et	c. 2	or Town, 8 3700 Barns	Street a State)	and Number	or Run	al Route Numb	er, City
Di ospital hours a neeral y filled	Certification:	4 / Homicide		ermined	1	Wood								-				
Division of Vital Interded Physician: hin 24 hours after death the Funeral Director: After this certifulation by the funeral director.		29a. Certifier 1	Certifying F	hysician	: To the be	st of my kn	owledge, de	eath occur	red at the	time, da	te and pla	ice, and d	ue to the caus	se(s) ar	nd manner a	s state	d.	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. After this certificate I completely filled in by the funeral director, page	Medical	one) 2 🗸	Medical Ex	aminer:0 ar	n the basis ad manner	of examina stated.	ation and/or	investigat	ion, in my	opinion,	death oc	curred at t	the time, date	and pla	ace, and du	e to the	cause(s)	
E 2 E 2	Me	29b. Signature and	title of certif		1	. ^			290	License	e number			29d.	Date signed	(Mon	th, Day, Year)	
		CPL	1 18	X	40	0 (),	XL	_		O.C.N	Л.E.			Apr	ril 4, 2007	7		
,	Ļ	30. Name and addr	ress of perso	n who con	npleted car	use of death	n (Item 23a)											
\		Carol Allan,				Examin		Penn S	Street,	Baltimo	ore, MD	21201						
						A												
Stat	te ar	31. Date filed (Mon	ADD O	6 2D	n7	19 49144	Signature	(Company										

Maria Socorro D		Otate of maryland / Department of the	alth and Mental Hy		LUB 1	() Light.
Physicia	an/	Registrar Amended#8 per FH FCHD, Regrificate of Dec 1. Decedent's Name (First, Middle,Last)		2. Date of Death	i. No.	3. Time of Death
Medical Exami		MARIA SOCORRO DANFORTH		April 3, 200		1517 hrs
,		4a. Facility Name (if not institution, give street and number) 4b. City 16700 Barnsville Road Boy	y, Town, or Location of Death yd		4c. County of Death Montgomery	
Funeral			nder 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Birti 2005_ Foreign	nplace (State or
Director		217-71-3409 1 M 2XF Z Yrs.	Titlis Days Hours Willi.	JAN 7	- 2007 Cou	ntry) MD
any	٦	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			Т	10d. Inside City Limits
Baltimore, MD 21215-0036 Department of Health and Mental Hygiene. Infortant: If iften 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner.		MD MONTGOMERY BOYDS				1 Yes 2 No
	Director		Zip Code 20841	100	. Citizen of What Coun	try?
	Funeral		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto No specify: MEX	Rican, etc.)	14. Race - Americ White, etc. Specify: W.	an Indian, Black, HITE
urs afte tural"	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	ual Occupation (Give kind of v	vork done	16b. Kind of Business/Ir	
215-0036 be filed within 72 ho ntal Hygiene. eked other than "na ent, the Medical Ex	To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of 0	working life. DO NOT use reti	red)		
		17. Father's Name (First, Middle, Last) GERARDO ROQUE	18.Mother's Name	(First, Middle, Ma		
212 ould be Menta marke c even		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	ess (Street and Number or F			Zip Code)
MD id 2 sho ulth and m 27 is			BARNESVILLE			
Baltimore, MD permit. Pages I and 2 sh Oepartment of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 20b. Place of Disposition (to crematory or other plants) 4 Donation 5 Other Specify:	ce)	Date 7 / 0 7	20c. Location - City or BEALLSVI	
Balti permit. Departr Import	İ	21. Signature of ne S rv e Licensee	ind Address of Facility ON FUNERAL BOX 86, BA	HOME RNESVII	T.E. MD	20838
Physician	by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	de of dying, such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Hanging Death				
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b				
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
cuted und transit		events resulting in death) Last Due to (or as a consequence of): d.				
60, te be executed ysician and		UNPENDED AMENDED				
, P.O. Box 6876i res that the death certificate signed by the attending phy be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 5 Other (S		ancy	23d. Date of delivery Month D	ay Year
hat the ed by the letached		Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.		acco use contribute to	
S, P, quires then signe en signe				24a. Was ar		opsy findings available
tal Records tian: The law requii certificate has been :	Completed			autops perform 1 ✓ Yes 2	y prior to c ned? death?	ompletion of cause of
an: T errifice ctor, pa	BeCc	25. Was case referred to medical	26 Place of Death (Check			
ision of Vir Attending Physir r death ector: After this by the funeral dir	To E	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	-		Residence 6 🗸 Other	Scene
		27. Manner of Death 1 Natural 5 Pending Pounds Day, Year) 28b. Date of Injury FOUND: Day, Year) FOUND: Apr 3, 2007 1517 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	Hanged by fa	ow injury occurred ather	
	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Woods April 3, 2007 1317 IIIS 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street or Town, State 16700 Barnsville			eet and Number or Rural Route Number, City te) e Road, Boyds, MD	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Ce	29a Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
To Toom	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo				nth, Day, Year)
		(arol Halla)	O.C.M.E.		April 4, 2007	
\	ij	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 6 2007 32. Refistrar's Signature	W.			
	_					

DHMH 17 Rev 1/2001

ORIGINAL

07-02776

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tephen T. Downs	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2 Date of Death 1. December 1. December 1. December 2. Date of Death 1. December 2. Date of Death 1. December 3.										
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last)	i i	Date of Death Month Day Year pril 12, 2007 3. Time of Death 0841 hrs								
,	4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Martha David Have Min	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washy)ngton DC								
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 Yes 2 X No								
the Maryland a or 28a-f show siffed at once Director	WV Jefferson Shephero	10f. Zip Code	10g. Citizen of What Country?								
r death with the look of items 23a or must be notified. Funeral Dit	167 Windgale Drive 11. Marital Status 1 Never Married 2 Married Armed Forces? 13.	25443 Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric									
s after deat iral", or ite niner must by Fun	3 Wildowed 4 X Divorced in res, Give real or Dates:	Yes 2 X No specify:	Specify: White								
5-0036 ed within 72 hour lygiene "natu other than "natu the Medical Exan Completed		Elementary/Secondary (0-12) College (1-4 or 5+) 2 during most of working life. DO NOT use retired) Wallpaper Contractor Construction									
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE Comple		rst, Middle, Maiden Surname) McCombs									
MD 212 nd 2 should be alth and Ment m 27 is mark aumatic ever	19a. Informant's Name/Relationship (Type, Print)	l Route Number, City or Town, State, Zip Code) Darnestown, Md. 20878									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Gate of	20c. Location - City or Town, State 117, Silver Spring, Md.									
Baltir permit. F Departme Importar	21. Signature of Funeral Service Licensee										
Physician /Medical Examiner	23a. Part I. Enter the disease, or compleations that caused the death. Do not en failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hy ertensive atheroscle Due to (or as a consequence of):		Between Onset and								
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
te be executed ysician and burial - transit	d. X UNPENDED AMENDED AMEDICAL AMEDICA	4/30/07 TT									
b. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of 4 path 10 unknown	Fetal death 3 Ectopic pregnance Other (Specify)	23d. Date of delivery Month Day Year								
P.O. B es that the de igned by the be detached i		the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the drafter deer. After this certificate has been signed by the led in by the funeral director, page 2 should be detached ertification: To Be Completed by Physrification: To Be Completed by Physicians			24a. Was an autopsy performed? 1 ✓ Yes 2 N 1 ✓ Yes 2 N N 1 ✓ Yes 2 No								
al Relan: The certificat ctor, pag	25. Was case referred to medical	26.Place of Death (Check onl									
n of Vita fing Physicia After this co funeral direc	1 V Yes 2 No Inpatient 2 V ER/Outpa	e of Injury 28c. Injury at Work? 28	Home 5 Residence 6 Other:								
Division o spital or Attending tours after death. nerral Director: After filled in by the fune Certification:	1 A Natural 5 Pending Investigation 3 Suicide 6 Could not be	1 Yes 2 No street, factory, office building, etc. 28	of Location (Street and Number or Rural Route Number, City or Town, State)								
O THE PORTS											
To the Ite within 24 To the Fu completel		29c. License number	29d, Date signed (Month, Day, Year)								
3	anes	O.C.M.E.	April 13, 2007								
		nn Street, Baltimore, MD 21201									
State Registra		book									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Margaret Ann Dail April 6 2007 7:40 a.^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 100 East Appleby Avenue Dorchester Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X F 215-26-4400 76 Maryland **Director** 16, 1931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Dorchester 1 Yes 2 No MD Cambridge Director 2 should be filed within 72 hours after death with the nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 East Appleby Avenue 21613 USA Funeral Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 ☐ Yes 2 █****No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) quality control publishing 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George W. McGinn <u>Nora Delaha</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Ellis daughter 5330 Bucktown Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/07 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Corcurate A Physician MOS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to make access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner the death certificate be executed as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? **P** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29b. Signature and title of certific

State Registrar 31. Date filed (Month)

32. Regidar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



307 Cellia

Hurlock

mil 6 2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene: Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year **Physician** Betty Easlev 4 01 07 12:05 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton 6000 Wolverton Lane Prince Georges if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2₩F Director 410-42-7340 3/26/30 Tennessee Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. Interest of them 27 is marked other than "natural", or items 23e or 28e-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No MD Clinton Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6000 Wolverton Lane 20735 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: black 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Supervisor other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Brown Edward Emory ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Shepherd/daughter 6000 Wolverton Lane Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Fort Lincoln Cemetery Department of important: If II any Injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/7/07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Hury Washington, DC 20002 Approximate Interval Between Onset and Death Part. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final diseese or condition resulting in death) Metastatic Endometrial Cancer Examiner Due to (or as a consequence of) Physiclan/Medical Examiner Attending Physician: The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Breast Cancer þ ours efter death.

Neral Director: After this certificete has been signs filled in by the funerel director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? Hypertension TL Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9 24 hours e 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Francine A. Higgs-Shipman MD 31. Dete filed (Month, Day, Year) APR 0 5 2007

29b. Signature and title of certifies

32. Registrar's Signature

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

9200 Basil Court, suite 200 Largo, MD 20774

29c. License number

D28079

29d. Date signed (Month, Day, Year)

4/4/07

Registrar

Marino

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Apr 12, 2007 Charles Edward Frankenberry 0:20 am M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 12710 Bunting Street Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Feb 1, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 □ F Μ̈́D 214-07-2590 90 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Allegany Cumberland 1 ¥Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 12710 Bunting Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 M Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No WW II Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) laborer Hiser Supply 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Sylvester Frankenberry Mary Elizabeth Weslow 19a, Informant's Name/Relationship (17) Kimberly Llewellyn 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11909 Homewood St, NW Cumberland MD 21502 Informant's Name/Relationship (Type, Print) niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 4/16/2007 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Nam Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition plon resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the ettending physicien as the esn detached for á peudis g page 2 should hes certificate filled in by the funeral director, this After t 24 hours after death Funerel Director:

Physician

/Medical

Examiner

Funeral

Director

28a-f ehow

or Iteme 23a or

Director

Funeral

ģ

Completed

Be

other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. snt: If item 27 is marked other then "natural", or ite

permit. Pages
Department of H
Importent: If ite
any Injury or of

Fnysician

/Medical

Examiner

Physician/Medical

þ

Completed

Be

ဥ

Certification:

Medical

Baltimore, Maryland 21215-0036

death with the Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cosonari

> 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? tnjury

1 Yes 2 No

investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

> 29c. License number D006047

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

KINT AVE. CUMPERLANT 31. Date filed (Month 92 32. Registrar's Signature

State Registrar

12

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#25, perPHYS, G866, 4/19/07, WS
State of Maryland / Department of Health and Mental Hygiene

			For State	State of Mar		artment of F rtificate of		-	gien Reg. N	-	10510
es.	in The State of th		Registrar 1. Decedent's Name (First, Middle, I	Last)	007	imouto or	Boain	2. Date of De	ath	- 4001	3. Time of Death
	Physicia /Medic		MILDRED LO	UISE FUNKH	IOUSER			APRIL	7.	ay Year 2007	12:40P M
	Examin	3.1	4a. Facility Name (If not institution, g	live street and number)	-	4b. City, Town, o	r Location of Death	1	4	c. County of Death	
			CIVISTA MEDIC 5. Social Security Number 6		(In yrs. last birthday)	LAPL If Under 1 Year	ATA If Under 24 Hrs.	8. Date of Bir	th	CHARLES	
	Funeral Director		235-30-5612	1 M 2 F 7. Age (84 Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Yeai	22 W.Va	place (State or Foreign ntry)
	rela della diale		Usual Residence of Decedent								
	arylar show	ř	MD . 10b. County	RLES	Ioc. City, Town or Lo	waldon	r.				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f notifie	Director	10e. Street and Number	KHES		10f. Zip Code			10a. C	itizen of What Cou	
	3a or		70 VILLAGE	STREET			601			.S.A.	•
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ameri Black, White	
UISE 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 □ Yes 2 □ No	Specify:	,		Specify: WH	
E E -0	d within 72 ho giene. r than "natur the Medical	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16a. Deced	dent's Usual Occup	nation during most of wor d)	king	16b.	Kind of Business/Ir	ndustry
151	within ene. than he Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		EMAKER	4)		_	WN HOME	
000	filed withi I Hygiene. other than ent, the M	Be C	17. Father's Name (First, Middle, La	2yrs.colle	age non	DIMILLI	18. Mother's Nan	ne (First, Middle			
land /	should be filed and Mental Hygie s marked other umatic event, ti	To B	FRANK BEEVE	ER			MARY E	· LOYNE'	TT		
ER.	0,00,00		19a. Informant's Name/Relationship GARY FUNKHO			•				or Town, State, Zi	'
US e, N	1 and 2 Health em 27		20a. Method of Disposition	JOSEK-SON	20b. Place of Dispo	sition (Name of	1	Date Date		Location - City or T	
HOLL	0 0 - -		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	. □Removal from State	cemetery, crer	matory or other pla ΔΝ CDFM	1	_11_07		ŕ	
FUNKHOUSER, Baltimore, Mary	permit. Pag Department Important: I any injury o		21. Signature of Furieral Service Lie) /22	2. Name and Addre	ess of Facility				
F. W.	an)		Muchoe	0.K	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	AYMOND A PLATA	FUNERAL MD. 20	SERVI 646	CE,	P.A.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that aused that one caus on each line.		^	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Wetista	tu Coln	~ Cance	~				
	Examiner		4	Die to (or as a d	consequence of):	Failur	_				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a r	Consequence of).						
Jan Jan	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						
68760,	ificate be executed g physician and as the burial-transit		,	Due to (or as a c	consequence or,						
687	ificate g phys	edical		d							
Вох	eath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2	f pregnancy	JEctopic pregnanc	v		1	23d. Date of deliv	*
	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	Other (specify) _				Month	Day Year
σ.	w requires that the d been signed by the should be detached		Part II. Other significant condition	s contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	equires en sign	ed by	anemia					1 🗆	Yes	2□ No 3□ Pro	bably 4 Donknown
ဝင္ပ	law re as bee 2 sho	Completed						24a. Was	psy	prior to c	opsy findings available ompletion of cause of
E R	siclan: The law s certificate has t irector, page 2 s	Com						perfe 1□ Yes	ormed?	death?	2 □ No
Vita	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	2000	t acipos Oth	26. Place of Dea				
o	y Phys er this eral dii	7: To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	28b. Time o			28d. Describe		6 □Other (Speciary occurred	ify)
ion	vtending F death. ctor: After y the funera	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) Injury		Yes 2 □ No				
Division or Vital Records, P.O	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (City or To		and Number or Ru tte)	ral Route Number,
	spital lours a neral / filled			Physician: To the best of							
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medical E.	xaminer: On the basis of e and manner state				urred at the time			
	Mith To t	Σ	29b. Signature and title of certifier	000		29c. Licen:				Date signed (Month	
			In dami	n U. Dyat	All (Home DD-) (T		5483	10		1-7-0-	/
	10		30. Name and address of person w				HTTF100	WAIDO	DE	MD 204	502
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar	's Signature		,0111100	WALDU	<u>' I\ I _</u>	עני עני א	J.U.Z.
	Registi	ar	APR 1 9 20	IUI please	12. Marie						

07-02767

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jane Dull Freund	1-For State Registrar Certificate of Death Reg No. 2007 265												
Physicia Medical Examin		Decedent's Nam JANE		•)				2. Date of Dea Month April 11, 2		аг	3. Time of Death 2005 hrs	
		4a. Facility Name (give street and nu	mber)		4b. City, Town, or Rockville	Location of Dea		4c. County			
Funeral Director		5. Social Security N 578-44-4	Number 6	Sex	7. Age (In yrs. 7.3	•	If Under 1 Yea			rth(MM/DD/YYY)	9. Birt	thplace (State or Information DC	
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locat	ion				_	10d. Inside City Limits	
and F show	5	MD	Montgo	mery		Rockvil	1e					1 Yes 2 X No	
e Mary or 28a-	Director	10e. Street and Nu		D			10f. Zip Code	50	1	l 0g. Citizen of W		•	
with th		13131 C1 11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13. Wa	208 as Decedent of His	panic Origin? (§	Specify Yes or No	United		can Indian, Black,	
ter death ", or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.										nite	
nours af	od be	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use setted)											
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home											
Baltimore, MD 21215-0036 bernit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. In Jiem 27 is marked other than ujury or other traumatic event, the Medical	Be Co	7. Father's Name (First, Middle, Last) John R. Dull Roberta Tolley											
ID 21 should I and Mer 7 is man			9a. Informant's Name/Relationship (Type, Print) Marvel Freund (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 13131 Cleveland Drive Rockville, Md. 20										
re, N s l and 2 of Health If item 2 rer fraus	ł		Oa. Method of Disposition Burial 2 X Cremation 3 Removal from State Oa. Method of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem. 13131 Cleveland Drive Rockville, Md. 2 20c. Location - City or April 13, Alexandri										
timo			Other Spe	cify:	Me			_	007	Alexa		a, VA	
Ba perm Depa Impo		Custo	. 0	min		10	lame and Address East De	er Park	Dr. gai	thersbu	rg.	Md. 20877	
Physician /Medical		23a Part I. Enter th failure. List onl				n. Do not enter ti	ne mode of dying,	such as cardiac	or respiratory arr	est, shock, or he	art	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (I or condition resulting		Due to (or as a	consequence o						_	Death	
	آةِ ق	Sequentially list con if any, leading to im	mediate	Due to (or as a							_		
e sit	xamin	(Disease or injury the events resulting in a	nat initiated	c. Due to (or as a	consequence o	or):		. =					
50, 1: be executed 1: sician and 2: burial - transit	Aedical Examiner	X UNPENDED		AMENDED #20. DEI	#23a-b.2 rME.g869	27, perME, 7/2/07	C869, 7/5/	07 TT					
8760, rtificat: be	an/Me	IF FEMALE: 23b, Was decedent past 12 months	pregnant in the	23c If yes, o	utcome of preg	nancy	tal death 3	Ectopic pregn	ancy	23d. Date of Month		ay Year	
Ce the came.	Physician/	1 Yes 2 🗸 N	lo 9 Unkn	9 Unkno		eath 5 Otl	ner (Specify)			10			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the representation of all Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detach.	2	Part II. Other signit	ficant condition	ns contributing to	death but not r	resulting in the u	nderlying cause g	iven in Part I.				the cause of death? ably 4 🗹 Unknown	
ords, v requir	Completed								24a. Was			opsy findings available ompletion of cause of	
Recc The lav icate ha	E C									rmed? o	leath?	_	
Vital Rec	Be	25. Was case referr examiner?		Hospital: 1 X In	patient 2	ER/Outpatient		of Death (Check Other Nursi		Residence 6		- Acette	
n of V	암	27. Manner of Death	(28a. Date o (Month,		28b. Time of I	njury 28c. Injur	y at Work?		how injury occurr	ed		
ision Attend or death. ector: by the f	catio	2 Accident	5 Pendin Investig	gation 28e Place	of Injury - At h	ome farm stree		es 2 No	28f ocation (Street and Number	er or Rui	al Route Number, City	
Division spiral or Attencours after death leral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined Coperity Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
To the Hos within 24 h To the Fun	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
- > - 0	ž	29b. Signature and	title of certifier	_11	- 6		29c. License O.C.M			29d. Date signed April 12, 20		th, Day, Year)	
		30. Name and addre	ess of person w	no completed caus	of death (Item	1.23a)	0.0.1			7.p.11 12, 20			
		Theodore M	. King, Jr., N	ID. Assistar	nt Medical E	Examiner	111 Penn Str	eet, Baltimor	e, MD 21201				
Star Registra	te ar	31 Date filed (Month, Day, Year) 2007 32 Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Bradford A. Francis 2007 April /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Takoma Park Montgomer If Under 24 Hrs Funeral 1**X**M 2□F Hours Wash, D.C. Feb. 12, 1920 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Nes 2 No Washingt Funeral Director 10g. Citizen of What Country? 10e, Street and Number U.S.A Blaine 20019 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oriver Construction 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Parge Beatrice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blaine St. N.E. Washington, D.C. 20019

20c. Location - City or Town, State Francis, wite Thelma 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mercer's Crematory April 6, 2007 Fredericksburg, Va, 22. Name and Address of Facility P.O. BOXII 21. Signature of Funeral Service Lie nsee Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Port Royal, Va. 22535 Immediate Cause (Final disease or condition resulting in death) CALDIOPULMONARY Physician /Medical Due to (or as a consequence of): **Examiner** MYOCARDIAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SEPTICEMIA the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Ves 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 🛣 No within 24 hours after death.

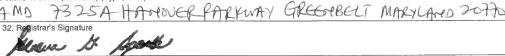
To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State Registrar

JIAKA MD

IMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

naka



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 4, 2007 **Physician** Linda Graham 6:16 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year
Aug. 6, 1938 Prince George's General Hospital Prince George's 5. Social Security Number Birthplace (State or Foreign Country)
 Indiana 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2007 F 68 213-38-3421 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 1 No Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 Allentown Road 20744 238 LISA fited within 72 hours after death Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 end 2 should be 1 Deperment of Health and Mental I Important: If Item 27 Is marked of any injury or other traumatic eve Homer Milton. Vera Ε. Hartig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Dale Graham / Husband 7920 Allentown Road Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 04/07/2007 Clinton, Maryland 21. Signatur Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA al 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE LUNG DISEASE **Physician** years resulting in death) /Medical Due to (or as a consequence of): Examiner HYPOXEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 7 years Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the Hospital or Atlending Physician: The law requires that the death certificate be executed RESPIRATORY FAILURE 3 months resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 31 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) dir ٥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: After 5 Pending de ath. 1 Tyes 2 No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 - Homicide n 24 hour. the Funeral Directilled in 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier yletely 2L Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title MD 414107 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHE 6130 Landover Road Cheverly, Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 0 5 2007

Physic /Medi Exami

	Pleas	e Type or Prin		II Copies A Iental Hygie	- 9						
	for State Registrar	State of Me		rtificate of			. No. 200	7 12653			
	1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death			
an al	Melie Gali	ch				April 2,	2007 Year	7:46 P M			
er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ith			
	Washington Adve	ntist Hospi	tal	Takom	a Park		Montg	omery			
	Social Security Number 6		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	rthplace (State or Foreign ountry)			
	208-24-8722	1 X M 2□F	74 Yrs.	World S Days	7 TOUTS WITT.	June 26,		nnsylvania			
	Usual Residence of Decedent		140 CU T	A!				40d Incide City Limits			
	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits			
cţo	Maryland Prince	George's				1X Yes 2 No					
ire	10e. Street and Number			10g. Citizen of What Country?							
by Funeral Director	3509 Madison Pl	ace	82	USA							
ner	11. Marital Status	12. Was Decedent Armed Forces?	ispanic Origin? (Sp	rigin? (Specify Yes or No- in, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							
Ē	1 ☐ Never Married 2 ☑ Marrie			TTLIA							
ρ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	Rolean	1 ☐ Yes 2 🖾 No	Specify:		Specify: W.	iii CC			
ted	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	ation	dina 1	6b. Kind of Business	s/Industry			
Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	kind of work done			Self Emp	1 oved			
S	12		Wall	. Paper Ha		o (First Middle Ma		Toyeu			
Be	17. Father's Name (First, Middle, La	ast)				ne (First, Middle, Maiden Surname)					
2	Peter Galich					Solasky					
	19a. Informant's Name/Relationship	p (Type. Print)	1	,			City or Town, State,				
	Doris E. Galich	- Wife		Madison			,	0782			
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	D □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Place of Disponentery, cre	osition (Name of ematory or other plac		Date 20	Oc. Location - City o	r Town, State			
	4 □ Donation 5 □ Other (Spe		Metropolita	n Cremator	y 4/5/	'2007 A	Alexandri	a, Virginia			
	21. Signature of Funeral Service Li	censed	2	2. Name and Addre	ss of Facility		4739 Balt	imore Ave.			
/	Trichelle (1	/ horpen	1017	sch's Fur			-	le, MD 20781			
	26a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused	the death. Do not en	ter the mode of dyir	ig, such as cardiac	or respiratory arres	t,	Approximate Interval Between			
	Immediate Cause (Final		16857	IVE H	9ART	FIA11	1106	Onset and Death			
	disease or condition resulting in death)	a. Due to (or as	a consequence of):								
		COR	OWARU	ARTO	FRY	D159 K	32	YC IARS			
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	1.00	. ,						
шļи	Cause (Disease or injury	DIM	BETES	Med	LITU	5					
Examine	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):		,						
_											
dic		d									
Мe	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of d	eliven			
ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	2 Fetal death 3	Ectopic pregnanc	/		Month	Day Year			
The past rainfuls: 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown											
Ph	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?			
Completed by Physician/Medical	END SM	GE RG	unc	DISER	92		2 □ No 3 □ I	/			
lete	PERIFERIA	L 1/12 S	CUCOR	DISC A	32	24a. Was an	24b. Were	autopsy findings available			
mp	1	V V) -3		1/1 ~1)		autopsy perform	prior to	completion of cause of			
ပိ	Or Man anno referred to me direct				00 Pi- 15			es 2 No			
Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only one)				

Inpatient

76	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
26. Place of Death (0	Check only one)	

212 No 1 Yeş 27. Manper of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be determined

3□ DOA 2 ER/Outpatient 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature a

JQ6

29d. Date signed (Month, Day, Year) April 2, 2007

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

MO

State Registrar

Medical Certification: To

itle of certifier



0

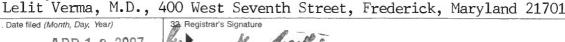
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #23PII, 25, 27, 28a-f&29a Certificate of Death 120/07 Jh 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL 9:28 A M 14 HORTON 2007 POLLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 16, 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F 244-36-1242 78 Director 1928 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Maryland Frederick Frederick 1 ☐ Yes 2 X No Directo with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code rai", or items 23a or Examiner must be 5210 Ernie Lane 21703 U.S.A. death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. The Forces?

Yes 2 No
Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ò Specify: White 3 ☐ Widowed 4 Noivorced Year or Dates "naturai" Completed Medicai 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Clerk (Specify only highest grade completed) and Mental Hygiene.

marked other than "
umatic event, the Mex College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Be George 2 Robbins Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Baviello, Son 5210 Ernie Lane, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place)
Randolph Mem Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State permit. Page Department o important: If any injury or Apr 16,2007 Asheboro, North Carolina 4 □ Donation 5 □ Other (Specify) 21. Signature I Funeral Service Licens Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUBDURAL **Physician** temmorita6 & /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed burial-transit Frederick County, Due to (or as a consequence of) P.O. Box 68760, physician the burial Physician/Medical Alan H. attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth in the past 12 months? 1☐ Yes 2☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ CerebralVascular Accident; Hypertention; Diabetes 2 No 3 Probably 4 Unknown 1 Tyes Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 210 No Division or Vital 1∐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) Apr 13,2007 0100a 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Swatural 5 Pending investigation after death. 1 ☐ Yes 2 X No Fell while getting up 2√Accident 3 Suicide the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State 5210 Ernie Lane Frederick, Maryland filled in by 4 Homicide At home 24 hours a To the Hospital **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only Medical within 24 hor To the Fune completely fi one) and manner stated 29b. Signature and title of Crtifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 1 9



W//eima

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-57796

April 15, 2007

DIVISION OF VIIAI RECORDS, P.O. DOX 00/00,	ì	Dalillore, Maryla
To the Hospital or Attending Physician: The law requires that the death certificate be executed	Ph / Ex	permit. Pages 1 and 2 should
within 24 hours after death.	ıy: Me	Department of Health and Mei
To the Funeral Director: After this certificate has been signed by the attending physician and	sid ed m	Important: If Item 27 Is marke
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		any injury or other traumatic

			Please	Type or Prin						-		•		
		For		State of Ma	aryland					/lental Hy	giene	0000		
		1 - State Registrar	(F)			Ce	rtificate	OT L	Death	2. Date of De	Reg. No	2001	3. Time of Death	Ĵ
Physicia	an	1. Decedent's Nam		^{ist)} ETTA HARDE]	ΛŤ					April	11,	200 ^{Year}	9:56 PM	
/Medic	-			e street and number)	IN		4b. City. To	own. or	Location of Death	<u>. </u>		County of Death	-	-
Examin	er	,		irsing & Re	hah (`ente			tburg			llegany		
Funeral		5. Social Security N	lumber 6. S	Sex 7. Age	e (In yrs. la		If Under 1	Year Days	if Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9 Rinth	nplace (State or Foreign	
Director		212-74-41	.95	¹ □M ² ₹ F 1	01	Yrs.	Months	Days	Hours Win.	2-26-1	906	MARYÏ	LAND	_
pui »		Usual Residence of 10a. State	f Decedent 10b. County		10c City.	Town or L	ocation						10d. Inside City Limits	_
fanyla shored at	ō		,	NTS7	,,	TBURG							1 ☐ Yes 2X No	
with the Maryland a or 28a-f show t be notified at	rect	MD 10e. Street and Nu	ALLEGA	INI	FRUS	IDUK	10f. Zip 0	Code			10g. Cit	izen of What Co	untry?	-
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	11305 PAR		RD NW				1532			UNI	TED STAT	res	
ours after death v ral", or items 23s Examiner must	nera	11. Marital Status		12. Was Decedent I	Ever in U.S	. 13.	Was Decede	ent of Hi	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or N	0-	14. Race - Amer Black, White		_
after or ite	Ē	1 Never Married 2 Married 1 Yes 2 No											ITE	
ours ral",	d by	3A Widowed 4 Divorced Year or Dates:									101 10			_
"natural	ete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)										ind of Business/I	ndustry	
withir ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Results of the DO NOT use retired) HOMEMAKER										N HOME		
filed Hygi Sther ent, t		8 HOMEMAKER 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Na									1			_
lid be lental rked o	To Be	JAMES SKIDMORE ELIZABE									P SK	IDMORE		
d 2 should be filed within 72 hou d 2 should be filed within 72 hou had mad Hyglend Hyglend 1 should be 1 should b			lame/Relationship						and Number or Ru		-		•	
and 2 ealth n 27 l		DELORES H	ARDEN DA	AUGHTER					BURG RD N					
S ten it		20a. Method of Dis	•	☐Removal from State	ce	metery, cre	osition (Name matory or oth	her plac		Date		ocation - City or		
Pag tment tant: jury		4 Donation	5 Other (Speci	fy)	SUN				ARK 4-14-		L	BERLAND,		_
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 215												
0.012.00		PIG.	the disease or con	polications that caused	the death	7/				-		,	Approximate	_
		shock, or hea	art failure. List only	one cause on each lii	ne.	Laca		6-	0 11	-4-			Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	on	a. ACW	a conseque	ence of	ocus		and a	arclic	רמ		2 hours	_
Examiner				COR	dnin	y.	Brto	eri	1 2	isers			years	
7 #	ner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or	onditions, mmediate erlying	Due to (or as	a conseque	ence of):		\neg		77			0	
ecute and trans	Examiner	Cause (Disease or that initiated event resulting in death)	S	c										_
De excian a	-	resulting in death)		Due to (or as	a consequ	ence or):								
icate be executed physician and s the burial-transit	Physician/Medica		•	d										_
death certific attending p	//Me	IF FEMALE: 23b. Was deceder	nt prognant	23c. If yes, outcome	pf pregnar	ncy						23d. Date of del	iverv	
death atter	ciar	in the past 12		1□Live birth 4□Pregnant at			□Ectopic pre □ Other <i>(spe</i>		y			Month	Day Year	
the cy the achec	hysi	9 ☐ Unknow	n	9□Unknown										_
w requires that the do been signed by the should be detached	by P	Part li. Other sign	ificant conditions	contributing to death b	ut not resul	ting in the	underlying ca	u <i>s</i> e giv	en in Part i.	23e. Did			the cause of death?	
en sig			sement	-	15%	多少	_mi p			1	Yes 2	.□No 3□Pr	obabiy 4 doknown	
law r as be 2 sh	Completed									24a. Wa aut	opsy	prior to o	topsy findings available completion of cause of	
The aate h	Son									per 1∐ Yes	formed?	death? 1 ☐ Yes	2□ No	
Physician: The lav this certificate has al director, page 2	Be (25. Was case refe examiner?	erred to medical	Hospital:				Oth	26. Place of Dea				<u> </u>	_
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	ှင	1 Yes 2		1 ☐ Inpatie		28b. Time	ent 3 DO/	A	4 Nursing H	lome 5 Res		6 ☐Other (Spec	cify)	_
ding h. After	tion	Natural	5 Pending investigation	(Month, Da		Injury	м	Bc. Injur Wor 1 □	rk? Yes 2∐No	200. 2000.20	, non inje	.,		
Atten deat ector: by the	fical	/2 ☐ Accident 3 ☐ Suicide	6 Could not be	28e. Place of inj	ury - At hor	ne, farm, s	treet, factory,	office					ural Route Number,	-
al or all Direction of the control o	erti	2/ Manner or Death Suitcide Accident 3 Suicide 4 Homicide Manual Suicide 4 Homicide Manual Suicide 4 Homicide Suicide Accident Suicide Suici												
ospit hours unera														
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directa	Medical	one)		and manner st					se number					_
with voice	2	29b. Signature and	a title of certifier					_				ate signed (Mont		
			Jem		leath (lea	00a\ (T:		- ال	21244		7	4/12/0	7	_
8		30. Name and add	aress of person who	completed cause of c	Power	dir	s, erint)	Fer	stourg	MM.	2150	37.		
Sta	ate	31. Date filed (Mo		32 Registr	rar's Signat	ure) in	1100		J. 1.01	/ 11 × / s			_
Regist		F	IPR 1 9 20	007 Lieure	15	10	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 1157AM Rena Mary Hicks 2007 APRIL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death UNION HOSPITAL Bow Street EIKTON Cecil Count 106 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🗓 F FEB 16, 1920 091-16-0933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 117 Chestnut Hill Lane 21921 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 □ Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Shortsleves Helen Pacquin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Hicks/Son 117 Chestnut Hill Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Gilpin Manor Date 20c. Location - City or Town, State 20a. Method of Disposition April 16, 1 M Burial 2 □ Cremation 3 □ Removal from State 2007 Elkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee usmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTAGE CARDIOMY OPATH year disease or condition resulting in death) Due to (or as a consequence of): CORON ARY years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

item 2

permit. Pages 1
Department of H
Important: If iter
any injury or oth

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

Completed by

Be

ို

Certification:

Medical

10a. State

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene.

1.27 is marked other than "natural", or items 23a or 28a-f show ar traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed physician and the burial-transit Box 68760 attending p

Division or Vital Records, P.O.

To the Hospital or Attending Physician:

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the i

been signed by the should be detached has e 2 page certificate director, this After thi funeral

IF FEMALE: 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

M.D.

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

4 ☐ Homicide

🛚 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

D0059223

BON St. Elkton, MD

Melchor E. Madarany 31. Date filed (Month, Day, Year) State

Registrar



106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08 07 07 Mont 04 Physician 1020 Harrison Ernest Leonard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany WMHS Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F 60 May 16,1946 Richwood, WV 236-70-7992 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2X No Director MD Allegany Rawlings 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a must 21309 Burke Hill Road, S.W. 21557 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify ģ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Heating & Air Conditioning Sheet Metal Fabricator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Mental F Be Leonard Clay Harrison Mary C. Banner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 21309 Burke Hill Road, S.W. Rawlings, MD 21557 Mary C. Harrison/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 11 Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kalbaugh Cemetery 2007 Elk Garden, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumource /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 cate has been sign page 2 should be 4 Jooknown 2 No 3 Probably 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2∏No 2 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

the

(Check only one)

29b. Signature and title of certified

29c. License number

25406

Box539, Cumberland, MD

29d. Date signed (Month, Day, Year)

APRIL 8,2007

and manner stated.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MONTH Physician 24. 2007 06:23PM BRENNER LOE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Towson Baltimore Center If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2 F march 24, 2007 MARQLAND NONE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYland BAltimore County Timonium 10g. Citizen of What Country? 10e. Street and Number USA 21093 2305 FOX EY ROAD 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT 6 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be MELINDA HELLMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 2305 FOXIEY ROAD Peter + melinda Hohing Timonium, MARYland DARENTS 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition APR:1 25, BAI timORE CITY, MARYLAND 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Holy REDEEMER CEMETERY 2007 Name and Address of Facility 7601 OSIER DRIVE 21. Signature of Fuscort Survice Licensee St. Joseph Medical Centur TOWSEN, MARVLAND ZIZOY 23a. Pa 11. miler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lost, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Important Cause (Final disease or condition resulting in death) 2.5HOURS EXTREME PREMATURITY-22 WEEK GESTATION Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and s the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties as IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29h. Signature and title of certifier

31. Date filed (Month, Day, Year)

MICHAEL

E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANGBAUM.

2007

M. D.

32 Registrar's Signature

29c. License number

D41343

7604 OSLER DRIVE TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:15 A M Humbles 04 01 07 Ethel May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Hyattsville Hyattsville Heartland Nursing Home 7. Age (In **81** If Under | Year | If Under 24 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 02 20 26 West Virginia Director 578-36-6899 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No **Funeral Director** D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20024 1200 Delaware Ave. S.W. #704 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Matthew J. Pankey Maggie R. Irvina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, D.C. Kelvin Humbles/Son 1914 Bryant St. N.E. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-07-07 Humbles cemetery Appomattox. VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home & maishall 4217 9th. st. N.W. Washington, d.C. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DIOPULMONAZI Physician /Medical Due to (or as a consequence of) OCASDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MULTIPLE MYELOMA Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐XNo 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 1 Inpatient P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation

Examiner law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760. physician the attending p ed by the a signed b been sig cate has t certificate Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

this After t n 24 hours after control of the Funeral Director: After the fu

To the I within 2.

State Registrar

6 ☐ Could not be

determined

29b. Signature and title of certifier MO

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

GREENBELT MARYLAND 20770 Dryellaka HATEOVER PARKWAY

1 ☐ Yes 2 ☐ No

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2007 LARRY Ε. HODGES APRIL 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days 1 ☑ M 2 □ F APRIL 14 1953 FLINT, MI 53 Director 372-58-6583 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 XYes 2 No Director MITCHELLVILLE PRINCE GEORGE'S MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20721 2009 FORMEADOW WAY Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ARMY Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: 9 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' College (1-4or 5+) 4+ Elementary/Secondary (0-12) GOVERNMENT CONSULTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAZEL. SMITH EDSEL HODGES traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important; If item 27 Is any injury or other trauonce. JONES/POA LOIS 2009 FORMEADOW WAY MITCHELLVILLE, MARYLAND 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 4/7/2007 BRENTWOOD, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature de une la Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME ALC 7474 LANDOVER ROAD LANDOVER, MARYLAND ~ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Interior. /Medical Due to (or as a co. equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed To the Hospin...
within 24 hours after death.
To the Funeral Director; After this certificate 1X Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar 30. Name and address of

31 Date filed Me

oth Day Year

0 6 2007

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician ODETTA** I. HICKMAN 313 200 DM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner KAGIONA SAI 156419 Nicomico EMMSKA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 7-7-1919 6. Sex 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 🔀 F DELAWARE 222-14-5858 87 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Counfy 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at DELAWARE SUSSEX SELBYVILLE 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 19975 12 POLLY BRANCH ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: þ Specify: WHITE Saltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALVA HARPER WILLIAM LYNCH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. REESE HICKMAN / HUSBAND 12 POLLY BRANCH RD., SELBYVILLE, DE., 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 DRemoval from State ROXANA CEMETERY 4-7-2007 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature of Funeral S MELSON FUNERAL SERVICES, THATCHER ST., FRANKFORD, 23a. Part1. Enter the dise shock, or heart failur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin **Physician** lumano disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Cause (Dissass or that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy perforn certificate 1∐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 No 1 K Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 27 Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the funeral

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E D. O. SIMONA

DHMH 17 Rev 1/2001

DW 8

Medical

State

Registrar

31. Date filed (Month, Day, Year) APR 0 6

32. Registrar's Signature

2007

			1 - For State Registrar	State of Ma		artment of H		R	eg. No.	12662	
	Dhysiai	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day Year	3. Time of Death	
4	Physici /Medio		Norman Donald 1					March 3		5:47P M	
	Examin	er	4a. Facility Name (If not institution, give	re street and number)			Location of Death	4c. County of Death	•		
			Union Hospital			E1kton	If Under 24 Hrs.	0.5.1.1.01.11	Cecil Cecil		
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. last birthday) 75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year) Cou	place (State or Foreign intry)	
	Director		219-28-0001 Usual Residence of Decedent		/5			Nov. 11	, 1931 Mar	yland	
	yland yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Mar st	to	Maryland Cecil		E1kton					1 ☐ Yes 21 No	
	or 28	ire	10e. Street and Number			10f. Zip Code		1	Og. Citîzen of What Cou	intry?	
	23a (Funeral Director	7 Robin Hood Dri	ve		2192	1		United Stat	es	
	ems erms	ıner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
36	s afte , or it amin	by Fu	1 Never Married 2 ₩ Married	1 GYes 2 □ No If Yes, Give	1950-54	1 ☐ Yes 2 💢 No			Specify: Whi	te	
Ö	72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Examinat must be notified at	d be	3 Widowed 4 Divorced	· · · · · · · · · · · · · · · · · · ·	1962	dent's Usual Occupa	ation				
5	in 72	ojete	15. Decedent's E (Specify onfy highest gr.	ade completed)	(Give	kind of work done of DO NOT use retired	during most of world	king	16b. Kind of Business/li	idustry	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene from 23a or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		lane Mech	anic		U.S. Govern	ment	
ğ	e filec I Hyg othe /ent,	Be C	17. Father's Name (First, Middle, Last)	1,,,				Maiden Sumame)		
lar	should be and Mental I smarked o	To E	Burton W. Holmes	S			Ruth W	ooda11			
Maryland	2 sho and h ls ma		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number	r, City or Town, State, Zi	p Code)	
	1 and Health tem 27 other tr		Catherine Holmes	/wife		bin Hood	Dr., Elk				
ore	ges 1 t of H If itel or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	e)	Date	20c. Location - City or T	own, State	
Ë	tant:		` 4 ☐ Donation 5 ☐ Other (Special		Brookview			2007 I	Rising Sun,	Maryland	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		21. Signature of Funeral Service Lice	nsee Joo					Funeral Ho un, Marylan		
			23a. Parti. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not en					Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	. ACUTE		ARDIAL	TNE	ARCTI	DN	Onset and Death	
	/Medical Examiner		resulting in death)	a	consequence of):						
)	LAGITATICI	<u>_</u>	Sequentially list conditions,	b. CORCA	Consequence of):	RTERY	DISE	1SE			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).						
	arecu al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and to age 2 should be detached for use as the burial transit			d							
68	tificat ig ph) as th	Physician/Medical									
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		∃Ectopic pregnancy			23d. Date of deliv	•	
). E	e dea he at led fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti 9□Unknown		Other (specify)			Month	Day Year	
P.0	that the de led by the a detached	Phy	9 Unknown Part II. Other significant conditions	contribution to death but	and consisting in the su		on in Donal	220 Did to	bacco use contribute to	the source of death?	
S,	ires tha signed I I be det	by	METASTATIC	LUNG	CANCE		en in Fatti.	256. Did to			
oro	w require been signature	etec	MEMBER	20104	CITIOCI	~					
Vital Records,	has l	Completed						24a. Was a autops perfor	sy prior to c	opsy findings available ompletion of cause of	
			00.11					1 Yes	2 No 1 ☐ Yes	2 No	
Ξ	Physician: r this certific ral director,) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	VERIO	Othe	00	th (Check only or	***		
of	Phys arthis aral dii	n; To	27. Manner of Death	1 Inpatient	28b. Time o	IL 3 DOA	4 Nursing H		ence 6 Other (Spec	(Y)	
ion	Attending I death. ctor: Atter y the funer	atio	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	Year) Injury		<br Yes 2 □ No				
Division of	l or Attending after death. Director: Aftel in by the fune	Certification;	3 Suicide 6 Could not be determined		y - At home, farm, sti (Specify)	reet, factory, office		28f. Location (S. City or Town	treet and Number or Rui n, State)	al Route Number,	
Ω	pital c urs af aral D illed ir		200 0 477 -								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medicel Example)	nysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the c rred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	111	N _	29c. License	number	2	9d. Date signed (Month	Day, Year)	
•			1 (17-Wes	rdel We	5	D 00	31154		4-3-200	7	
	a. WA		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)		#			
	1+1			UENOEL,	MD: 111	W. High	Street	202	Elkton, 1	10 21921	
	Sta Registr		APR 6 200	7 Element	s signature	de "			H-3-200		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Howar Matthew Garre 17:46 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Citu The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) March 30, 1998 Maryland ge (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 219-51-9289 9 Director Usual Residence of Decedent 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Dorchester Cambridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 948 Hudson Rd. 21613 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ρ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Never Worked</u> <u>None</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Howard Laura Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Howard/Father 948 Hudson Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Spedden-Seward Cemetery 4/5/2007 Cambridge, Maryland 4 □ Donation 5 □ Other (Specify) Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 21/8 gnature of Fune al Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of): blackfan syndrome Diamond Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by palsy, tracheostomy, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 1 ☐ Yes 2 No 27. Manner of D th Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

The law requires that the death certificate be executed the burial-transit or Vital Records, P.O. Box 68760, physician for use ed by the a page 2 should certificate has Physician: funeral director, this After or Attending 24 hours after death. • Funeral Director: A filled in by

Hospital

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be

permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical

Physician /Medical Examiner

Baltimore,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Kim Fredericksen, Medical Doctor

Res-000

April 01, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vim Gredericuser, the Johns Hopkins Hospital, 600 North Worke Street, monyland 21287 31. Date filed (Month, Day, Year)

State Registrar

completely

within 2.

4 Homicide

APR 0 9

			For	State of N		id / Depa	artmen	t of H	ealth a	and M		giene	2. 8:4	100	a pa 8
			1 - State Registrar	 		Cei	rtificate	e of L	Death			Reg. No.	U/	120	004
П	Physici	an	1. Decedent's Name (First, Middle, Therese Iten	Last)							2. Date of De. April	10, Day 20	07 ^{Year}	3. Time o	P. M
	/Medio Examin		4a. Facility Name (If not institution,	give street and number	or)		4b. City.	Town, or	Location of	of Death	710111		nty of Death		F • ···
	LAdiiii	ic:	1306 M. Scotts		,			el A					ford		
	Funeral			6. Sex 7. / 1 ☐ M 2X F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin Month, Da 10/23/	h V. Year)	9. Birth	place (State	or Foreign
	Director		220-34-6253 Usual Residence of Decedent	1 M 201 F	94	Yrs.					10/23/	1912	Ger	many	
	/land		10a. State 10b. County		10c. Cit	y, Town or La	cation							10d. Inside C	City Limits
	a-f sh	tor	MD Harf	ford		Bel	Air							1 🗆 Yes	s 2√□ No
	ith the	Dire	10e. Street and Number				10f. Zip					10g. Citizen		intry?	
	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show the Medical Examinal rivel be notified at	by Funeral Director	1306 M Scottsda		- 1 5 · · · · i - 1 1	0 10 1		2101				U.S			
, o	fter de	Fun	11. Marital Status 1 ☐ Never Married 2 ★ Marrie	12. Was Deceder Armed Force ad 1 □ Yes 24	s?						ecify Yes or No Rican, etc.)	14. H	lace - Ameri lack, White		
99	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	2 X No	Specify:			Spe	city: Wh	ite	
9	72 hc	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Deced	kind of wor	rk done d	urina mos	t of worki	ing	16b. Kind of	Business/Ir	ndustry	
12	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Homen	nakor	ie retired)				In ho	mo		
Maryland 21215-0036	filed Hygid other ent,	Be Co	17. Father's Name (First, Middle, L	ast)		TIONG	IIIANEL		18. Mothe	r's Name	(First, Middle,				
<u>lan</u>	uld be Jental rked tic ev	To B	Josef Eichhamme	r					Mar	gare	te Raab)			
lar	2 sho and h is me		19a. Informant's Name/Relationsh								I Route Numbe	r, City or Tov	vn, State, Zi	p Code)	
	1 and 1ealth sm 27 ther tr		Albert Iten (Hu	sband)	20h B		M So				ve, E	el Air			1015
0	ages nt of h t: If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		Han	Place of Dispo emetery, cren rford N	natory or of	ther place	9) Edne		6/07	20c. Locatio		own, State Maryla	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		'4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service 4		1101								-	магута	IIG
ä	Depa Impo any ir		Kurkenth	must (NO	USK	VX	Tarr	ing-(leen	Cargo Mar	Fun vlan	eral Ho d 2100	me, P. 1-3399	Α.		
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caus	ed the deat	h. Do not ente	er the mode	e of dying	, such as	cardiae o	or respiratory ar	rest,		Approxima Interval Be	te tween
. 7	Physician		Immediate Cause (Final disease or condition	a		nphy	1 se	ma						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):								- to	-28-30-0
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	uence of):									
2.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,									
,09/	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or a	as a conseq	uence of):									
∞ .	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	dical		d											
9 X	death certific attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	incv						224 5	Data of dollar		
Вох	death a atten d for u	Ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	Ectopic pre						Date of deliv Month	,	Year
P.0.	the de	hys	9 Unknown/	9□ Unknown											
	res that igned t be deta	ру Р	Part II. Other significant condition	s contributing to death	but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.			bacco use co			
ord	w require been sign	eted									1 🗆 Y	es 2□No	3 Pro	bably 4 🕡	dhknown
Records,	has b	Completed									24a. Was autop		prior to co death?	opsy findings impletion of c	available cause of
	ician: The certificate h rector, page	e Co	25. Was case referred to medicat								1 Tes	2 No	1 Yes	2□ No	
5	ysicia	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 🗍	ER/Outpatien	t 3 🗆 DO	A Othe			ne 5 ☑ Resid		ther (Speci	fv)	
Division of Vital	or Attending Physician: Iter death. Director: After this certifics in by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In	ijury	28b. Time of Injury		Bc. Injury Work			28d. Describe h			97	
Sio	ttendir death. ctor: Af y the ful	catlo	2 ☐ Accident investiga	ition		,2.,	М		es 2 🗆 l	-					
Ž	al or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, stre	et, factory	, office		2	28f. Location (S City or Tow		mber or Run	al Route Nun	nber,
_	spital ours a neral filled		29a. Certifier 1 Certifying	Physician: To the bes	st of my kno	wiedge, death	occurred a	at the time	e. date and	d place, a	and due to the	ause(s) and	manner as s	tated	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	xaminer: On the basis and manner:	of examinal	tion and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the time,	date and place	e, and due t	o the cause(s	s)
	To the comp	Σ	29b. Signature and title of certifier	4				License				29d. Date sign			
			1 (1)				4	035	5013	3		APM	1 10	2,20	07
	10		30. Name and address of person w	no completed cause of		23a) (Type, I	Print)	Nor	46	12.10	Bel	Air	Md.	21014	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture		, - , ,	, , ,	VIVE	- 1001			/	
	Registr		APR 1 9 200	1 Block	1.	MORNEL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month : Day Ann DOLLY JO NES 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1760 Kins Hospital 8. Date of Birth (Month, Day, Year) na 1 h M0 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Min. 1□ M 2□ F Months Days Hours 225234925 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 12 Yes 2 □ No **Funeral Director** drio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1□Yes 2 No Specify: Specify: Black δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>xecialist</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Typę. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R St. Husband 1715 Cameron Jones Alexandria VA 22314 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 0 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Lice 22. Name and Address of Facility Funeral Home Franklin Street, Alexandria V 23a. Part1. Enter the shock, or heart e disease, t failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or contion resulting in death) **Physician** CERVICAL CANCER /Medical Due to (or as a consequence of): Examiner DEEP VEIN THROMBOSIS Sequentially list conditions, if any, leading to infine drate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BICATERAL Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à GASTROINTESTINAL BLEED 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an INSUFFICIENCY certificate has autopsy perform 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 1 Impatient 2 I ER/Outpatient 3 I DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records,

31. Date filed (Month, Day, APR 0 5 2007

29b. Signature and title of certifier

6,

KUMAR PANIGRAHI, M.D 32. Registrar's Signature D.

and manner stated.

5 h

· grah.

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RABI KUMAR PANICRAHI M.D 600 NORTH WOLFE STREET, BALTIMORE

RABI KUMAR PANICRAHI M.D 600 NORTH WOLFE STREET, BALTIMORE

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

APRIL 2nd

Physician /Medical Examiner law requires that the death certificate be executed burial-tran the attending pl

Funeral

Director

r 28a-f show notified at

items 23a or 2 iner must be n

ı "natural", or items ledical Exa⊓iner m

er than "natur , the Medical I

marked other

s 1 and 2 should be fill f Health and Mental Hitem 27 is marked oth other traumatic even

Department of Health Important: If item 27 any injury or other ti

Pages 1

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

signed by I be detail funeral director, page 2 s this After filled in by

Division or Vital Records, P.O. Box 68760, Hospital or Attending death. 24 hours after death Funeral Director: within 2. 2

State

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

YUDH V. GUPTA M.D.

29b. Signature and title of certifier

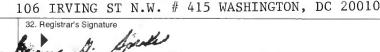
3 Suicide

29a. Certifier

4 Homicide

(Check only

6 Could not be determined



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

0

			artment of Health a	, ,	ene g. Nó. 0 0 7	1266
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) MARTITA KIBS 4a Fecility Name (If not institution, give street and numbers)	mber)	4b. City, Tow	2. Date of Deeth Month n, or Location of Death	Day Year 200 4c. County of Dea	
Funeral Director	5. Social Security Number 5.77 64 5933 Usuel Residence of Decedent 10a. State 10b. County	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year If Under 2 Months Days Hours	TIMORE 4 Hrs. 8. Date of Birth Min. Nov.11,1		thplace (State or Fore ountry) Shington, D
the Marylan r 28a-1 show notified at	Virginia Fauquier	Bealeton	10f. Zip Code	10	g. Citizen of Whet Co	1 ☐ Yes 2√
within 72 hours after death with the Maryland ene. The han "natural", or items 23a or 28s-f show the Marical Evention must be notified at the Marical Evention must be notified at ompleted by Funeral Director.	1 Never Married 2 Married 1 Yes If Yes, Gi	2 🖾 No ve	22712 Was Decedent of Hispenic Origin If Yes, specify Cuban, Mexican, 1□ Yes 2⊠ No Specify:		U.S.A. 14. Race - Ame Black, Whit	erican Indian,
be filed within 72 hour tal Hygiene. d other than "natural" event, the Medical Ex event, the Medical Ex Be Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (12	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of DO NOT use retired) Secretary	f working	6b. Kind of Business.	/industry
Mental Harked out	James M. Halcombe		Dorot	s Name <i>(First, Middle, M</i> hy Emma Dav	is	1000
permit. Pages 1 and 2 should be filled within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mones. To Be Comp	19a. Informant's Name/Relationship (Type, Print) James D. Kilby (husband) 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	6732 20b. Place of Dispo	matory or other place)	est, Bealet		L 2 Town, State
pemit. Departm Importa any inju	21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility loser Funeral H	23	3 Broadvie	ew Ave
Physician /Medical Examiner	b		er the mode of dying, such as ca oniくのおかい quence of):			Approximate Interval Between Onset and Death
anding physician and ruse as the burial-transit and Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseq				
cate has been signed by the attending page 2 should be deteched for use a Completed by Physician/M	Part II. Other significant conditions contributing to de	eath but not resulting in the u	ndertying cause given in Part I.		acco use contribute	to the cause of dear
ins law raquinas marina daain centra ata has been signed by the attending page 2 should be datached for use a completed by Physician/M				24a. Wes en performe	ed?	Were eutopsy finding available prior to completion of cause of deeth?
ysician: Inalia ils certificata has I director, page 2 To Be Comp	25. Was case referred to medical examiner?		26. Place of	1 ☐ Yes		1 □ Yes 2 □ No
anding Privath. W: After the funeral he funeral sation:	1 Yes 2 No Hospital: 1 1 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece	h, Dey Year) Injury of Injury - At home, farm, str	28c. Injury et Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	v injury occurred eet and Number or Ru	
to the hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 29 (Certifying Physician: To the bardinal Examiner: On the bard and mann	sis of examination end/or inv	occurred at the time, date and prestigation, in my opinion, death	City or Town, place, and due to the ceu occurred at the time, dat	ise(s) and manner as	steted. to the cause(s)
within To the comple	29b. Signature and title of certifier CFMENTA MD		29c. License number D 3 4 9 7 8	+ A	d. Date signed (Month	2007
12	30. Name and eddress of person who completed cause CHARU MEHTA, MD, 601		Print) Street, Ba	ltimore, n	1D 2123	0
State Registrar	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature	els)			

DHMH 16 Rev 6/95

		1 = For State Registrar	State of Marylar			f Health and of Death		jiene leg. No.	007	12668	}
Discosioni		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death	
Physici /Medio			a Mae Kline				Apri1	11	2007	2310 P	л
Examir		4a. Facility Name (If not institution, give st				m, or Location of Deat	h		ounty of Death		
		117 West Thomson Dr 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday	E1k1		8. Date of Birth		Cecil	place (State or Foreig	an .
Funeral Director		218-26-6927	м 2 X F 89	Yrs.		ays Hours Min.		1918	Cour	nsylvania	
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo	ocation			-	1	0d. Inside City Limit	
8a-f.	Director	Maryland Cecil	E	1kton	1.24 71.0			10- 011	n of What Cour		_
with ti	D.	10e. Street and Number			10f. Zip Co				ited Sta	•	
eath	eral	129 Wesley Street 11. Marital Status	2. Was Decedent Ever in U	J.S. 13.	Was Decedent		Specify Yes or No-		. Race - Americ		_
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "netural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinating the notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 ☐	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	to Rican, etc.)		Black, White, pecify: Whit		
furai		15. Decedent's Educ		16a. Dece	dent's Usual C	ccupation		16b. Kind	of Business/In		
n n	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work of DO NOT use i	one during most of wo atired)	orking				
the diameter of the state of th	Completed	12	College (17401 37)	Ad	minist	ative Assi	istant	Αe	erospac	e	
be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, McCa11	Maiden Su	umame)		
ould Men Marks	ို	James McMonagle		101 14 10				. 047	Faura Ctata Zio	Code)	
12 sh n and n and r ls rr		19a. Informant's Name/Relationship (Typ				reet and Number or R					
is 1 and of Health item 27 other tr		Deborah L. Morgan/G	30h	Place of Diene	cition (Nama	4			tion - City or To		
Pages nent of I int: if it		1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State Im	cemetery cre macula	matory or othe	Apr	il 16,				ı
그런런 중 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	I Ce	metery		, 200			у ніті,	, Maryland	1
Depermine Deperm		21. Signature of Furieral Service Electrise	400	H	icks Ho	ddress of Facility me for Fun tockton St	erals, P	A.	Marula	nd 21021	
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the dea						rial y 1	Approximate	
		shock, or heart failure. List only one Immediate Cause (Final	e cause on each in 4.							Interval Between Onset and Death	and the same of
Physician /Medical		disease or condition resulting in death)		DW	0	ince	1		-	141	
Examiner			Due to (of as a conse	quence on:						1	
	ě	Sequentially list conditions, b.	Due to (or as a curse	quanta of)	-						_
te be executed ysicien and le burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
n and ial-tra	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
ysicie ne bur	cal	d									
ng ph as t	Med	IC CEMALE:									-
e attending phy od for use as th	an/A	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel		⊒Ectopic pregi	nancy		23	d. Date of deliv Month	ery Day Year	
the att	hysician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown	death 5{	Other (speci	(y)			WONG	Duy	
ed by	by Phy	Part II. Other significant conditions con-	tributing to death but not re	sulting in the u	inderlying caus	e given in Part I.	23e. Did to	obacco use	e contribute to	the cause of death?	
been signed by the attending phys should be detached for use as the							101	res 2	No 3□Pro	bably 4 Unknow	ΝΠ
shou	ompleted						24a. Was	an	24b. Were aut	opsy findings availab	ole
The law requires that the the bes been signed by the bage 2 should be detached.	Ę							rmed?	death?	ompletion of cause o	d
	ပို	25. Was case referred to medical				as Place of Dr	1 ☐ Yes eath (Check only o	-	1 🗆 Yes	211 NO	-
nis certificete hes l	o Be	examiner?	ospital: 1 Inpatient 2 [☐ ER/Outpatie	nt 3 DOA				Other (Spec	Pagidoneo	S
Attending Proyecten: r death. ector: After this certification the funeral director.	1-	27. Mann Death	28a. Date of Injury	28b. Time o		Injury at	28d. Describe h			" Kesidence	
th. :: After thi	tlor	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No					
after death	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, o	ffice	28f. Location (S City or Tox		Number or Rui	al Route Number,	
To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edicai Co		icien: To the best of my kr ier: On the basis of examinand manner stated.								
To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. L	icense number		29d. Date	signed (Month)	Day, Year)	
F × F		255 Sunday Bard IIIO ST SOLITION		12	THE	MELL	149	11	116/	07	
		0/0-0	moleted cause of death (the	m 23a) /Tura	Print	NU		$-\frac{\gamma}{l}$	1101	1/2/93	2/
		80. Name and address of person who co	mpreted Cause of death (ite	11 20a) (1ype		LICL	5 +	, 20	> 11	Ann MID	1
le	1	2 Dina Dimon	C-1 1 1/1 1	11 / / /	2011	100	1 1 1 1 4	E - 10.		1011	

Division or Vital Records, P.O. Box 68760

within 24 hours To the Funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 924 SETON DRIVE VIK POONAI, M.D. 31. Date filed (Month, Day, Year) State APR 1 9 2007 Registrar

CUMBERLAND, MD 21502 32. Registrar's Signature

Medical

(Check only one)

29b. Signature and title of certilier

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D36766

29d. Date signed (Month, Day, Year)

			For State	State o	f Marylar	•	rtment of H		and Me	ental Hy	giene			
100	F 6		Registrar 1. Decedent's Name (First, Middle, L	aet)		Cer	tificate of	Death		2. Date of Dea	Reg. No. 3. Time of Death			170
	Physici		DENNI	ŕ			KERN	c		Month	Day	Year		Death M
	/Medi Examir		4a. Facility Name (If not institution, g		mber)		4b. City, Town, o			04		2007 ounty of Death	2035	
		(d)	WMHS-BRAD	DOCK CAM	IPUS		CUMBERI	LAND			AL	LEGANY		
	Funeral Director		705-14-0298	Sex 1 <mark>x</mark> □M 2□F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day 12-20-	h v, Year)		place (State or ntry) WV	Foreign
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	eation					14	0d. Inside Cit	v Limite
	Maryla f sho ied at	ō	,			Cumberl							1 ▼ Yes	
	r 28a	Director	MD Allega 10e. Street and Number	Шу	'	cumber	10f. Zip Code				10g. Citizer	of What Cour	ntry?	
	th with	a D	901 Seton Drive				21	502				USA		
	rr dea tems er mu	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Speci	fy Yes or No-	14.	Race - Americ Black, White,		
36	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gi Year or D	ve		□Yes 2√2No	Specify:		, , ,		ecify:		
9	2 hour atural cal Ex	ed k	15. Decedent's		ates.	16a. Deced	ent's Usual Occup	ation				whi of Business/Ind		
215	hin 72 e. an "na Media	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give life. E	kind of work done of NOT use retired	during most d)	of working	' 1			200119	
21	ed wil	Con	12				n/a					n/a		
Maryland 21215-0036	t be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Las Penton Kerns	st)						^{First, Middle,} Jane R		,		
Ž	should nd Me mark matic	P	19a. Informant's Name/Relationship	19b. Mailin	g Address (Street						Code)			
Ž	alth a		Charlotte Jones	niece			86 Box 6						0000)	
ore	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3]	Demousl from		Place of Dispos cemetery, cren	sition (Name of natory or other place	ce)	Dat	te	20c. Locati	ion - City or To	wn, State	
Baltimore,	. Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Spec	rify)	Sca	_	Funeral			/2007		aptown,		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service Lic	ensee	MI	/ 22 Sh	Name and Address	ss of Facility rnick	Scar Fune	pelli ral Ho	Funer me, R	al Home	P.A. WV	for
			23a. First the disease, or co shock, or heart failure. List on	np ications that o	aused the deat	h. Do not ente	er the mode of dyin	g, such as o	cardiac or r	respiratory ar	rest,		Approximate Interval Betw	/een
N.	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. en	dstag	e co	PD.						Onset and D	1.1
	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):						1		
		ler	Sequentially list conditions, if any, leading to immediate	b Due to	uence of):									
ß.	cuted nd ransit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events	C										
8760,	cate be executed ohysician and the burial-transit	EX	resulting in death) Last	Due to	or as a conseq	uence of):								
387		dical		d										
Box (that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregna						23d.	. Date of delive	ery	
B	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		oirth 2 Feta eant at time of d		Ectopic pregnancy Other (specify)						•	ear
P.O.	hat the d by ti letach	Phy	9 ☐ Unknown Part II. Other significant conditions			ulting in the un	darkina agusa aiye	on in Dort I	-	220 Did to	bassa usa			-450
Vital Records,	The law requires that the death certifithe has been signed by the attending bage 2 should be detached for use as	ed by	Sepsis	_	irome			en m Fan I.	_		es 2 🗆 N	contribute to th lo 3 ☐ Prob		nknown
Sec	ne law r has be ge 2 sh	Completed								24a. Was a	sy	4b. Were auto	psy findings a	vailable use of
a	ician: The certificate harector, page									perfor 1∐ Yes	med? 2 4 No	death?	2 4 No	
<u> </u>	nysician; nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 D No	Hospital:	npatient 2	ER/Outpatient	3 DOA Othe			Check only or				
0	ding Phys h. After this funeral di	压力	27. Manner of Death	28a. Date		28b. Time of	28c. Injury Work	4 LI NUI		d. Describe h		Other (Specif)	/)	
Sior	endin sath. or: Af the fur	atio	1 Matural 5 Pending 2 Accident investigation	on .	n, Day Tear)	Injury		Yes 2□N	10					
Division or	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	Zoe. Place	of injury - At ho ng, etc. <i>(Specif</i>)	ome, farm, stre	et, factory, office		28f	Location (S City or Town		umber or Rura	l Route Numb	er,
_	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying F	hysician: To the	best of my kno	wledge, death	occurred at the tin	ne, date and	d place, and	d due to the c	ause(s) and	d manner as st	ated.	
	the Ho iin 24 I the Fu tpletel	Medical	(Check only 2 Medical Exa	miner: On the ba	asis of examina	tion and/or inv	estigation, in my o	pinion, deat	th occurred	at the time, o	date and pla	ice, and due to	the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Efhr	1.1	0	29c. License	number	2 7 1-	2	29d. Date si	gned (Month, i	Day, Year)	
		-		700	~ /2	20.)=	<i>V</i> 0	ノロコラ	345		Apr	1 12	200	7
	1			completed caus	e of death (Item 8 Taun	1 23a) (Type, F	29c, License VC Trint) ace Fr	osthi	vy 1	4021	532		ĺ	
*	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 20	07 J.R	egistrar's Signa	ture			-					

			ricuse	State of Ma								aiene	.09.01			and March 1
			1 - For State Registrar	Otato or ma) (tificate					Reg. No.	200	1	12	571
	¥		Decedent's Name (First, Middle, Las	")				-			2. Date of Dea	ath Day	Ye	ar	3. Time o	of Death
	Physicia /Medic		Donald C. Kau	fmann							April	6	200	7	07:	01 AM
	Examin		4a. Facility Name (If not institution, give				-		Location o	of Death		4c.	County of D			
			219 South Main St 5. Social Security Number 6. Se		(In vrs. la	st birthday)	INO If Under		East If Under:	24 Hrs.	8. Date of Birt	h	Cecil	Birthpla	ice (State	or Foreign
	Funeral Director			2 M 2□ F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Oct. 7	y, Year) 192		Count	y) York	-
7	3		Usual Residence of Decedent													City Limits
9	ehow dat	<u>_</u>	10a, State 10b. County			Town or Lo										s 2X No
1	28a-1	ecto	PA Tioga 10e. Street and Number		Wel	1sbor	0 10f. Zip	Code				10a. Citiz	en of Wha	t Count	ry?	
4	be lied within 72 nouts after usean with the maryland tal Hygiene. Ital Hygiene. do other than "naturel", or items 23s or 28s-f show event, if a Medical Examinar must be notified at	Funeral Director	1162 Shumway Hill					6901					ed St			
4	ms 23	era	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. \				gin? (Spe	ecify Yes or No- Rican, etc.)	-	4. Race - A			
9	or its	Fu	1 ☐ Never Married 2 ☐ Married	1 XYes 2 □ N If Yes, Give		I .	1 ☐ Yes		Specify:		indan, otoly		Specify: V			
3	ure!,	d by	3€Widowed 4 □ Divorced	Year or Dates:	Marin	es			ntion				nd of Busin			
2	"nat	lete	15. Decedent's Ed (Specify only highest gra-	de completed)		16a. Deced (Give life. L	kind of wo DO NOT us	rk done d	during most	t of worki	ng	TOD. IXII	id of busin	932/110	usity	
7	the state of the s	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		Elect:	rical	Eng	ineer			Aeı	ospac	ce		
2	z should be tited v and Mental Hygie is marked other t aumatic event, II	Bec	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Surname)			
2	should bind Ments marked	10	Jacob John Kaufma	ınn							Kubic					
0	raum		19a. Informant's Name/Relationship (7				•				I Route Numbe					001
ני ע	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		Caye Ciabattoni /	Daughter	20b. Pla	ce of Dispo	sition (Nar	ne of		et,	North I	Zast., 20c. Lo	Mary cation - City	y Lar y or To	vn, State	901
2	permit. Pages 1 an Depertment of Heat Important: if Item 2 any injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	St.	Pete:	natory or c	tner plac	(e)	Apr	i1	7-11-	. h	Dom	m av 1	ronio
	ortan Finium		21. Signature of Emergy Service Line		⊥ Cat	Pete:	Ceme 2. Name ar	tery	ss of Facilit	ty C	2007 trouch I				пѕут	Vaula_
ŏ	Depermine any in		Ville Hold			1	27 So	uth	Main		et, Nor				ylan	d21901
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each lin	the death.	Do not ent	ter the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,			Approxim Interval B Onset and	ate etween
, F	hysician		tmmediate Cause (Final disease or condition	a Ca	zdio	myop	xilty							7	inko,	
	/Medical Examiner		Due to (or as a consequence of): Artery disease									1	Contra	Do 442 A		
		je je	Sequentially list conditions,	b. Due to (or as a	a conseque	<i></i>	101-00	1 4	1500	9E				-	vnr.	nown
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													
ວົ	te be executed ysicien end te burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):										
0000	ate be hysici the bu	Icai														
Ď :	certificate nding phys use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnan	ncv							23d. Date o	delive	0/	
DOX	death of attended for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	□Ectopic p □ Other (s		<i>'</i>			'	Month		Day	Year
<u>.</u>	the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown												
r.	w requires that the death certificate been signed by the attending phys should be detached for use as the	by P	ratii. Otto agricultus of the state of the s													
cords,	equire en sig	ted	(an cer of	120S191R	an	a se	ada	ee			10	Yes 2	No3[Prob	ably 4 b	Onknown
ပ္ပ	lawr lesbe	Completed									24a. Was		prio	re autop or to cor oth?	osy finding noletion o	s available cause of
	: The cate he page	Co									1 Yes	2 PNo		Yes	2 No	
VITA	ysician: The lav is certificate hes director, page 2	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2□ E	ER/Outpatie	ot 3[] D	Oth	ar		ath <i>(Check only one)</i> Home 5 ☑ Residence 6 □ Other <i>(Specity)</i>					
0	ding Phys th. After this funeral dir	n: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time o		28c. Injur Wor	y at	diam'g ()	28d. Describe			(0,000)	<u></u>	
5	ath. or: Aft	atio	1 Natural 5 Pending investigation	1	y roar,		М		Yes 2]No						
	r Atte	ertification:	3 Suicide 6 Could not b determined	28e. Ptace of Injuding, et	ury - At hor c. (Specify,	me, farm, st	reet, factor	y, office			28f. Location (City or To	Street an wn, State	d Number (or Rura	l Route M	umber,
_	urs af	O	29a. Certifier 1 Certifying Pt	ysician: To the best	of my know	wladza dost	th converse	Lat the tu	mo data a	ad place	and due to the	callee(e	and mann	Ar ac c	ated	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai		niner: On the basis of and manner sta	f examinati ated.	ion and/or in	vestigation	n, in my	pinion, dea	ath occur	red at the time,	date and	place, and	due to	the cause	e(s)
	within To the compl	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Da	te signed (/	Month,	Day, Year	,
)	-		> Hachel	WS MD				1003	2332	2		Ap	Eil 6	12	007	
			30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	211	3R	F	and due to the red at the time,	MD	2192	1.		
2	04 (VK		31. Date filed (Month, Day, Year)	32. Ragistr	/ 0 /	ture,		1		, _						
	St. Regist	ate	APR 6	2007	we.	K. A	1034									

			1 - For State Registrar	State of M	Maryland		artment rtificate					giene Reg. No. 2	107	12672					
	Physici		Nollie Plogramski						2. Date of De Month March	nath Day	Year 2007	3. Time of Death 4:15 a M							
	/Medic Examir		ALL FORMAN AND AND AND AND AND AND AND AND AND A					4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel							
	Funeral Director				Age (In yrs. la	ast birthday) Yrs.	If Under 1		If Under Hours	Min.	8. Date of Bir (Month, Da Oct. 2	*h	9. Birth	place (State or Foreign intry) Insylvania					
	ehow	ž	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel		, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2∰ No					
	with the M a or 28a-f be patifie	Director	10e. Street and Number 305 College Par				10f. Zip (Code 210	12			10g. Citizen of		ntry?					
036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f ehow he Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Nover Married 2 Divorced	12. Was Deceder Armed Force	s? ☑ No	1	Was Decede f Yes, specif	ent of Hi		gin? (Spe n, Puerto	ocify Yes or No Rican, etc.)	9- 14. Ra Bla Speci	ck, White,	can Indian,					
Maryland 21215-0036	ad within 72 ho rgiene. er than "natur t, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 5	grade completed) College (1-40	or 5+)	(Give life. l	tent's Usual kind of work DO NOT use	done d retired)	uring most	t of workii	ng	Shamoki Shirt E	n An	thracite					
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sac or 28a-1 ehow injury or other treumatic event, the Madical Examiner must be notified at Once.	To Be	17. Father's Name (First, Middle, Li Frank Zaneski	ast)					Ann	ne Ba	bin	, Maiden Suma							
e, Mar			19a. Informant's Name/Relationshi Theresa Heinritz		Tan a	781	Divid	ling				Park, I	MD 21	146					
Baltimore,		18	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	e ce	ace of Dispo metery, crem Saint	natory or oth	ner place	e)]	Apri 200	1 4,	20c. Location Elysbu							
Ba	Depar Impor eny ir	5 19	21. Signature of Funeral Service Li	plh		B 4	Name and arrance 95 Gov	co & 7. R	Sons itchi	e Hw	y. Sev	verna Pa	ark F	uneral Home MD 21146					
	Physician /Medical Examiner	resulting in death) Due to (or as a consequence of):								rrest,		Approximate Interval Between Onset and Death							
8760,	icate be executed physicien and s the burial-transit	by Physician/Medical	by Physician/Medical	by Physician/Medical	by Physician/Medical	cal Examiner	ical Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	C								
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th					IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Who 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal o	death 3	Ectopic prec						ate of deliver	ery Day Year		
rds, P	es to ed					۾	þ	þ	Þ	23e. Did tobacco use contributing to death out not resulting in the underlying cause given in Part I.									
Division of Vital Records,	The law recete has be page 2 sho	Completed							-			med?	Were auto prior to co death?	psy findings available impletion of cause of					
Z E	slcian s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		'D(O, ++-	40.004	1 Other	/		Check only o		11.001						
on of	Attending Physician: The ir death. ector: After this certificate he by the funeral director, page	1 Inpatient 2 ER/Outpatient 3 DDA 4 Unursing Home 5 Residence 6 Other (S									(y)								
Divis	or At	27. Manne Death 1 atural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Work? M 1 Yes 2 No 28d. Describe how injury occurs 28d. Describe how injury 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs 28d. Describe how injury occurs									Street and Numi vn. State)	oer or Rura	al Route Number,						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best taminer: On the basis and manner s	of examination	rledge, death on and/or inv	occurred at estigation, in	the time	e, date and inion, deat	d place, a h occurre	nd due to the d d at the time, d	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)					
)	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	12		MD	29c. I	License	number) 56	72	5	29d. Date signe	d (Month,	Day, Year) - 2007					
	\bigcirc		30. Name and address of person when they have	lie dina	V 86	23a) (Type, F	rint) tera	nst	Hur	N	illers	ville	M	Day, Year) - 2007 D 21/08					
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 4	2007 33 legis	trar's Signatu	4	WE		0				,						

			4 101	partment of Health and I ertificate of Death		ene g. No: 00	7 12673					
	Physici											
4	/Medio Examir		4a. Facility Name (If not institution, give street and number) 130 Brent Road	4b. City, Town, or Location of Death Arnold	n	4c. County of Anne	Death Arundel					
· *	Funeral Director		5. Social Security Number 216-34-3651 6. Sex © M 2 F 7. Age (In yrs. last birthda	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan. 13,	Year)	Birthplace (State or Foreign Country) Maryland					
	he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ins MD Anne Arundel Arnold 1									
9036	ath with II	rai Dire	130 Brent Road	10f. Zip Code 21012	10	og. Citizen of Wh.						
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumatic event, the Macinal Examinar must be nutified at	d by Funerai	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1960 − If Yes, Give Year or Dates: 1965	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2√√ No Specify: 		Black, Specify:	American Indian, White, etc. White					
Maryland 21215-0036	d within 72 h giene. er than "nate	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Cert		a. Kind of Business/Industry Accounting							
and	ould be fited v Mental Hygie verked other t	To Be C	17. Father's Name (First, Middle, Last) John Joseph Kenny		ne (First, Middle, M ia Stylc	faiden Sumame)						
_	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatice		19a. Informant's Name/Relationship (Type, Print) Paula T. Kenny/Wife 13	City or Town, St. D 21012	ate, Zip Code)							
altimore,	Pag nent int: I		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	position (Name of rematory or other place) Crematory 200	ch 30,	Baltimo	ore, MD					
Ball	Departr Imports any inju		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Barranco & Sons, I 495 Gov. Ritchie I	P.A. Seve	erna Par erna Par	k Funeral Hom					
8760,	Physician / Medical Examiner and prize pri	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac		st,	Approximate Interval Between Onset and Death Onset Approximate Onset Approximate Onset Approximate Onset Approximate Onset Approximate					
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	,					
٥.	quires that in signed by	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.									
Reco		Completed			24a. Was an autopsy perform	red? pric	ere autopsy findings available or to completion of cause of ath? Yes 2 Doo					
Vita	Physician: The raths certificate har all director, page	o Be	25. Was case relerred to medical examiner? 1 Yes	Othor	ath (Check only one	***************************************	(5					
Division of Vital Records,	or Attending Ph for death. Irector: After th by the funeral	Certification: T	27. Manner of Death Shatural 5 Pending	e of Work? M 1 Yes 2 No	28d. Describe how	w injury occurred						
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medical Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and mann ite and place, and	ner as stated. d due to the cause(s)					
)	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	vs.	3-3	Month, Day, Year)					
	Q,		30. Name and address of person who completed cause of death (Item 23a) (Typ. Charles Wu, Mb 1600 S. Crain	Huy Ste. 106, Gile	n Burnie	MD 2	MOGI					
(A)	Sta Regist	rar	31. Date liled (Month, Day, Year) APR 0 4 2007	food		•						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** S. LANORE MARCH 30 2007 2:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSA NURSING HOME VILLA MITCHEVILLE PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 ဩ F Months 522-20-2010 84 Director COLORADO Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at MD PRINCE GEORGE'S 1X Yes 2 □ No Director WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 LOVELACE COURT 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify: 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/ h and Menta! Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12th CASHIER CLERK PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GERTRUDE HERMOND JAMES SALVAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m eny injury or other traum 2005. 3001 LOVELACE COURT WALDORF, MARYLAND 20602 RICHARD LANORE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEMETERY 4/4/2007 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ALZHEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed FAILURE TO THRIVE that initiated events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has autopsy this certificate 1□ Yes Division of Vital 2 No To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Cther: 4√ Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2₺ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. (Check only one) 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) D32261 APRIL 3 2007 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) RICHARD FELDMAN M.D. 9500 ANNAPOLIS ROAD SUITE A-4 LANHAM, MARYLAND 20706 31. Date filed (Month, Day, Year)
APR 0 5 2007 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Month Day **Physician** 6:40 A M Brigitte McGuigan April 5 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFURD Se Air Health and Kehabilitatin Cente If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 2/15/1932 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖸 F 75 Germany Director 222-22-7269 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2XXVo **Funeral Director** MD Harford Aberdeen 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3307 Nova Scotia Road U.S.A. 21001 permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ^ any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be To Friedrich Landmesser Anna Welker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3307 Nova Scotia Rd., James A. McGuigan (Husband) Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/07 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA Tarring-Cargo Funeral Home P.A. 21. Signature of Funeral Service Licenses Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical o (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

one)

30. Name and address

29b. Signature and title of certifier

Year) R 1 9

2007

the

person who completed cause of death (Jem 23a) (Type, Print)

6 C Registrar's Signature 29c. License number

29d. Date-signed-fMonth, Day, Year,

		State of Maryland / Depart				
	_	State Registrar Certif	ficate of Death	Reg.		
Physicia		1. Decedent's Name (First, Middle, Last)			3. Time of Death	
/Medic	al	BEATRICE MARILYN MCFARLAND	b. City, Town, or Location of Death		, 2007 8:00 A M	
Examin	er	4a. Facility Name (If not institution, give street and number) WMHS-Frostburg Nursing & Rehab Ctr	Frostburg		Allegany	
Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign	
Funeral Director		217-10-5215	Ionths Days Hours Min.	(Month, Day, Yell 3-25-1919	MARY LAND	
/land ow		10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits	
Man,	tor	MD ALLEGANY FROSTBURG			1 □Yes 2 No	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 11313UPPER GEORGES CREEK RD SW	10f. Zip Code 21532		Citizen of What Country? [TED STATES	
death ms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.	
after or ite	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No If Yes, Give 1 ☐	Yes 2X No Specify:		Specify: WHITE	
ours iral",	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		405		
"natu	ete	(Specify only highest grade completed) (Give kin	t's Usual Occupation d of work done during most of work NOT use retired)		. Kind of Business/Industry	
withir ene. than he Mo	Completed	Elementary/Secondary (0-12) College (1-4or 5+) CO OWI	·	CAI	R DEALERSHIP	
filed Hygi other ent, tl	Ö	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
lid be lental rked c	To Be	EMIL KAMAUF	MILLICEN	r cooper i	KAMAUF	
2 shou and N is mar			Address (Street and Number or Run			
and lealth m 27					FROSTBURG, MD 21532 Location - City or Town, State	
Pages 1 nent of H int: If Ite		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State CIMBERT AND	ory or other place) CREMATORY 4-14-		MBERLAND, MD	
it. Pa intmer intanti injury		4 Donation 5 Other (Specify)	ame and Address of Facility		W. MAIN STREET	
permit. Depart Import any in		My SOWICKS MOOS47 SOW	ERS FUNERAL HOME	, P.A. FR	OSTBURG, MD 21532	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
Physician			DANIC RENA	1 PALL	Onset and Death	
/Medical		resulting in death) Due to (or as a consequence of):	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	7,5,7		
Examiner		Immediate Cause (Final disease or condition resulting in death) a. ACUTE AND CHI Due to (or as a consequence of): b. ARTEMO SCEDOT	7c CANDIOVA	eathar	DISENSE 2045	
sit ad	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c				
	ā					
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	u.				
n cert	M/ul	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ed	ctopic pregnancy		23d. Date of delivery	
deatl	sicia	in the past 12 months? 4 □ Pregnant at time of death 5 □ O		Month Day Year		
at the by the	hy	9 Unknown	220 Did tohan	co use contribute to the cause of death?		
res th	þ	Part II. Other significant conditions contributing to death but not resulting in the under	1 Yes 2 No 3 Probably 4 Unknown			
requi	sted					
las e 2	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?	
		25. Was case referred to medical	OC Place of Deat	1 Yes 2. h (Check only one)		
s certi	o Be	examiner?	0.11		e 6 □Other (Specify)	
Attending Physician: r death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe how i		
ath. r: Aft	atio	2 Accident investigation				
r Atte er dea irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)	
urs aft rrai Di			coursed at the time, data and place	and due to the cours	and manner as stated	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death o 2 ☐ Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)	
To the within To the complex	Me	29b. Signature and title of Cartifier	29c. License number		Date signed (Month, Day, Year)	
		· Chipsen Concin	D001316	20	4/13/2007	
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	E Frestburg, 1	Nd 21522		
Sta	te	31. Date filed (Month, Day, Year) Registrar's Signature	1 Coloury	10. 21002		
Registi		APR 1 9 2007 Januar 15 Sport	200			

DHMH 17 Rev 1/2001

Registrar

			1_ For	State of Maryland	/ Depar		lealth and I	Mental Hygie	ne,	7 12678	
			Registrar		Certi	ilicale of	Dealii	2. Date of Death	No.	3. Time of Death	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	- 9 <u>-</u> 8	11 00	/		Month	Day Ye	ar	
	/Medic		CATHERINE			GAN		1 4	(1 0	1 1 1 20	
*	Examin	er	4a. Facility Name (If not institution, give s			•	r Location of Death	1	4c. County of D		
		1	4748-G Flanders 1			Harwo		Lo Data (Dist	Anne Ai		
	Funeral		5. Social Security Number 6. Sex	M SITTE		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9.	Birthplace (State or Foreign Country)	
	Director		217-52-3132	58	115.			Nov. 19,	1948 Wa	shington, DC	
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits	
	lanyl sho	5				1				1 ☐ Yes 21 No	
	28e-1	Director	Maryland Anne At	rundel	Harwoo	10f. Zip Code		100	. Citizen of Wha	t Country?	
	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23a or 23e-f show he Medical Examera must be molified at		4748-G Flanders La	770		207	176		USA		
	eath	Funeral		12. Was Decedent Ever in U.S.	13. W			pecify Yes or No-		American Indian,	
	itan	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 x No	lf.	Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black, V	Vhite, etc.	
33	Irs al	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1.0	☐ Yes 2☐xNo	Specify:		Specify:	White	
ğ	2 hou	ed	15. Decedent's Educ		16a. Decede	nt's Usual Occup	ation	16	b. Kind of Busin	ess/Industry	
7.	nin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	ina or work done O NOT use retired	during most of wor d)	king			
21	d with	Completed	10	Solisgo (1 tol 51)	С	1erk		S	tate His	ghway Admin.	
ᅙ	be filed within 72 hours after death with the Marylan had tygione. Id Hygione. Id other then "natural", or Items 23e or 28e-1 show or other then "natural", or Items 23e or 28e-1 show event, the Medical Extra metricular be indiffed at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)		
<u>a</u>	should ba nd Mental markad c imatic eve	ToE	George Woo	odrow Bra	dy, Sr	•	Agnes	W	•	Sturgess	
ary			19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street	and Number or Au	ral Route Number, (City or Town, Sta	te, Zip Code)	
Baltimore, Maryland 21215-0036	1 and 2 Health a tem 27 is		Juanita Boswell/Da					arwood, M	aryland	20776	
Te	ss 1 ar		20a. Method of Disposition	20b. Placen	ce of Disposi netery, crema	ition (Name of atory or other plac	се)	Date 20	c. Location - City	y or Town, State	
Ĕ	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 图 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	Bri	asfield	d-Echols	Cr. 4/10	5/2007 Cl	narlotte	Hall, MD	
= =	mit.		21. Signature of Funeral Service Licens		22.	Name and Addre	ss of Facility	Present II	D /		
m	permi Depa Impo any ir		Your / Sant	M00641	36	195 Thre	e Notch	Rd., Char	lotte Ha	11, MD 20622	
1	Pnysician /Medical Examiner	Iner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Lind Light.	Due to (or as a conseque	nce of):	JPD	g, control			Interval Batwaen Onset and Death # M & N	
	uted d ansit	듄	Cause (Disease or injury								
	be exacuted ician and burial-transit	Exam	that initiated events cresulting in death) Last	Due to (or as a conseque	nce of):						
760,	sicia sicia e buri	call									
.89	ification of phy as the										
.O. Box	The law requires that the death certificate be exacuted ta bash signad by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date o Month	23d. Date of delivery Month Day Year	
ا ت	that t		Part II. Other significant conditions con	ntributing to death but not result	ing in the und	derlying cause giv	ren in Part I.	23e. Did toba	cco use contribu	te to the cause of death?	
of Vital Records,	sign d be	d by						1 ☐ Yes	2 □ No 3 (Probably 4 Dunknown	
Ö	w requira baan sij should b	Completed						24a, Was an	24h Wer	e autopsy findings available	
ž	has has	пр						autopsy	prio dea	r to completion of cause of the	
<u>=</u>								1□ Yes 2	No 1 🗆	Yes 2□ No	
Ë	Physicien: Th r this certificata ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		Oth	or	ath (Check only one)			
of	Phys this aldir	2	1 Yes 2 No	1 □ Inpatient 2 □ E	R/Outpatient 8b. Time of	3 DOA 28c. Inju	4 [] Indising i	lome 5 Residen 28d. Describe how		Specify)	
L C	ding Ph h. After th funeral	0	1 Natural 5 Pending	(Month, Day Year)	Injury	§ Wai	rk? Yes 2∐No		()		
Sic	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	a form stra			28f Location (Stre	et and Number (or Rural Route Number,	
Division	or A	Certification:	4 Homicide determined	building, etc. (Specify)	10, 141111, 3(16)	er, ractory, once		City or Town,			
]	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the tilestigation, in my o	me, date and place opinion, death occ	e, and due to the cau arred at the time, dat	se(s) and manno e and place, and	er as stated. I due to the cause(s)	
	thin the straight	Me	and a state of the	-utis		29c. Licens	se number	290	I. Date signed (A	Month, Day, Year)	
	5. <u>₹</u> 5 g		WWW.	hief Medical C he Chesapeake	rricer		21438		4/1	2/07	
(11		30. Name and address of person who co		(3a) /Tune 📮		214J0		() (14	
X	55		Michael J. LaPe				way, Anna	apolis, MI	21401	/	
	Sta Regist		31. Date filed (Month Day, Year)	3 Registrar's Signatu	ге	وخاره					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** 7:00 P M April 2007 Elsie Mae Kemp Moler 4. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Beverly Healthcare Center Washington Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Oct 15, 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Yrs. Director 82 1924 West Virginia 234-60-3256 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits XXYes 2 □ No Directo MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 1 Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Domestic Help Private Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Belle Tabler George M. Kemp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Wood Oak Court Baltimore, MD 21236 Virginia Calaguas/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ②Cremation 3 ☐ Removal from State Chesapeake Crematory 04/06/07 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 NO M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Antic Stemoses **Physician** Years /Medical Due to (or as a consequence of) Examiner 54 ears ConaEsTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 200 No this certificate 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 eu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.G. fluel nell JMW HA PU 368 32. Registrar's Signature 31. Date filed (Month, Day, State marie Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 04 13 2007 1934 NELSON IRENE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Mar. 8, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours 1 M 2 F Yrs. WV Director 236-78-5006 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Director WV Fort Ashby Mineral 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 26719 Rt. 2 Box 273 Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2₺ No Specify: white Specify. þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tem 27 is marked of other traumatic ev Stella Susan Iman John M. Swick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 273; Fort Ashby, WV 26719 John M. Nelson/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot tx Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2007 Petersburg, WV Maple Hill Cem. 4 Donation Ø ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. for 21. Signature of Funeral Septice Licensee Schaeffer Funeral Home, Petersburg, WV 26847 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate use (Final LUNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 2 No 2 MNo 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident Director: in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 5 31. Date filed (Month, Day, Year) APR 1 9 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** A^{M} April 16, 2007 6:15 OLIVER WINSTON PRICE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 7, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1X M 2□ F 80 Pennsylvania 209-20-6325 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No Frederick Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21701 U.S.A. 501 Prospect Blvd, 24D Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No 1946 - If Yes, Give Year or Dates: 1949 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Saltimore, Maryland 21215-0036 Ş 3 ☐ Widowed 4 ☐ Divorced 1949 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

I is marked other than "natur traumatic event, the Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Electrical Technician 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Anna Wakefield Be 17. Father's Name (First, Middle, Last) Price and 2 should be Herbert Lester ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Prospect Blvd, 24D, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type. Print) Mrs. Dorothy Price, Wife Health a Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem Gardens Apr 19, 2007 Frederick, Maryland 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig at ve of Funeral Servi icensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAY Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CANCER PROSTATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ding p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> CAD, CAROTTO DISEASE, CVA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊡ Unknown Completed HYPERTENUION, HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No performed 2 No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

10

Registrar

newon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONELSON MD 65C 32. Registrar's Signature DZ1936 4/16/07

THOMAS VOITHION DR FREDERICK 21702

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 1555 РМ APRIL RALPH EARNEST PRESSMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY FROSTBURG FROSTBURG VILLAGE NURSING CENTER If Under 1 Year If Under 24 Hrs. Min. B. Date of Birth (Month, Day, Year) 11-24-1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🕅 M 2□ F FROSTBURG, MD 89 Director 213-16-9903 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show or then "neturel", or items 23s or 28a-f show the W. dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director CUMBERLAND ALLEGANY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21502 13301 WINCHESTER ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", or Item any injury or other treumatic event, the Motical Experiment ODG. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE MAINTENANCE 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA SCHRAMM PRESSMAN STANLEY PRESSMAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13301 WINCHESTER ROAD, CUMBERLAND, MD 21502 WIFE DORIS PRESSMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 4-16-2007 CUMBERLAND, MD ¹ 4 □ Donation
² 5 □ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature, f Funeral Service Licensee Sowers morsing 60 W. MAIN STREET, FROSTBURG, MD 21532 Jon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 104 OBSTRUCTIVE LUNG CHRUNIC Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No > ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No 3□ DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient P 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Helhn Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 5 Bishop Rd. Cumberland, Md. 21502 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Apr 13, 2007 Proudfoot 2:00 pm ^м /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 31 Mullen Street Cumberland If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth Month, Day, Oct 30, Birthplace (State or Foreign Country)
 D 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ XF 213-22-2621 Director 90 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits other traumatic event, the Madical Examinar must be notified at Allegany Cumberland MD Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Mullen Street 21502 USA or iteme 23a Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 1.2 should be filed within 7.5 h and Mental Hygiene. 7 is marked other than "n. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hughes W. Burke Helen (Handel) Burke 19a. Informant's Name/Relationship (Type, Print)
Brenda Wheeler 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12115 Scenic Drive NE Cumberland MD 21502 daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Hillcrest Memorial Park 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2007 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nam Scarpetti Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each tine. Approximate Interval Between Onset and Death 2 403 Immediate Cause (Finat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time ol death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes : After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 30 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-ENatural 5 Pending death. 1 ☐ Yes 2 ☐ No iours after death.

neret Director: A
tilled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certific

Registrar DHMH 17 Rev 1/2001

State

Proudfest

30 Name and address of person who of pleted cause of death (Item 23a) (Type, Print) Sunt K. Gusta, M.D. (25 Keitt

2 Registrar's Signature

1) 5.

State Registrar

DHMH 17 Rev 1/2001

APR 0 6 2007

31. Date filed (Month, Day, Year,



arsol

re figurely

alconu

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRTL 2 2007 MARY PHILPOT 8:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCH 23 1928 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 □ F 579-34-0032 79 Yrs. VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at 1X Yes 2 □ No Directo LANHAM PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 238 20706 10317 BROOM LANE death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify ģ 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. GOVERNMENT SECRETARY 12th 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other treumatic event SDRS. 17. Father's Name (First, Middle, Last) Be ADA BRANDON UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6917 LAMONT DRIVE LANHAM, MARYLAND 20706 19a. Informant's Name/Relationship (Type, Print) MARILYN D. WRIGHT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4/7/07 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Sicensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner DISTRESS ARDS - ADULT RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitei or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent prognant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 ☐ Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ate has been sign page 2 should be 2No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 X No 1 ☐ Yes No No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 25 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 🖺 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number Mys 30. Name and of person who completed cause of death (Item 23a) (Type, Print) eriu Mahn 3001 HOSP DR 31. Date filed PR 32. Registrar's Signature State Registrar

Scott D. Pennington State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 10, 2007 1333 hrs Medical Examiner Scott David Pennington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 612 Robinson Station Road Severna Park Anne Arundel 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 220-86-5324 42 Country) 09/25/1964 2 F Yrs MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Severna Park 1 Yes 2 X No 28a-f show with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 612 Robinson Station Road 21146 USA 23я 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 2 XMarried 1 Never Married 2 X No 1 Yes White Yes 2 X No specify: Specify: permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner. 3 Widowed 4 Divorced If Yes, Give Year ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Eagle Alliance Computer Consultant 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jimmy David Pennington Cherie Lee Blackiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn M. Pennington/Wife 612 Robinson Station Road, Severna Park, MD 21146 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr. 13, 1 X Burial 2 Cremation 3 Removal from State Bestgate Memorial Annapolis, MD 2007 Donation 5 Other Specify: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licenses Cen art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Mixed drug (Hydrochodone, chlorpheniramine and loraze and Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): In OXICATION Sequentially list conditions, Examiner if any, leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and sician/Medical X UNPENDED AMENDED #23a,27,28a-f, perME, attending physician or use as the burial g867, 5/2/07 TT P.O. Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. φ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury Certification: Natural 1 Yes 2X No Director: d in by the f Fnd 4/10/2007 Fnd 1:27 pm <u>subject ingested drugs</u> Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 612 Robinson Station Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide 6 Could not be within 24 hours al To the Funeral E completely filled determined (Specify) Found at residence Severna Park. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 11, 2007 hi mo O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Lina Li. MD 31. Date filed (Month, Pay Year) 6 32. Resistrar's Signature State 2007 Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3^{Day} Month 4 2007 ear **Physician** Odell Ray Robinson 1:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday Social Security Number **Funeral** Days 1 □ M 2 □ F Hours 72 Director 226-40-6597 9/21/1934 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov amply injury or other traumatic event, the Medical Examiner must be notified at once. 1√Yes 2□No MD Montgomery Director Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11628 Stewart Lane Apt#104 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 No Baltimore, Maryland 21215-0036 B1ack Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Lawyer Mayfield Estelle Champ ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earnest Robinson Sr./Husband 11628 Stewart Lane Apt#104, Silver Spring,MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) Ft. Lincoln Cemetery 4/7/2007 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home permit. 3401 Bladensburg Rd, Brentwood, MD 20722 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cell Lung Cancer 1 year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of) Box 68760, IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 3 Probably 4 □Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page ; performed? ∕es 2∐No 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 ☐ No 2 ER/Outpatient 3 DOA 1 🔯 Inpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury (Month, Day Year, 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide filled 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) title of certific 29b. Signature D33224 April 3, 2007

State

Registrar APR 0 5 2007

31. Date filed (Month, Day, Year)



Dr. Ram Trehan 1400 Forest Glen Rd, #635 Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ieneva F. Rious		- For State	St	ate of Mar	yland /		rtment ο tificate o			на пу		∋g. No.	200	7 1258
Physicia Medical Examir	n/	1. Decedent's Name		e,Last)	R-	lous			-		2. Date of Deal Month March 31 ,		Year	3. Time of Death 1349 hrs
,		4a. Facility Name (i	f not institutio	n, give street and		Cub		-	Town, or Location	on of Death	Water on	4c.	County of Dear	
Funeral		Southern Ma 5. Social Security N		6. Sex	7. Age	e (In yrs. la	ast birthday)	Clinto If Und		nder 24Hrs.	8. Date of Bir		D/YYYY) 9. B	rthplace (State or
Director		251-66-08	339	1 M 2x	F	67	Yrs	Month 3.	s Days Ho	urs Min.	July	10,	1939 Fore	ountry) S.C.
any		Usual Residence of 10a. State	Decedent 10b. County			10c. City,	Town or Local	tion						10d. Inside City Limits
	٥	MD		George's		Ter	mple Hil							1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Nur		venue	#243			10f. Zip	Code 20748		1	0g. Citiz	en of What Co	untry?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	eral	11. Marital Status		12. Was	Decedent	Ever in U.		as Decede	ent of Hispanic (fy Cuban, Mexic			- 1		rican Indian, Black,
er death	Funeral	Never Marrie Widowed		orced If Yes, Give	es 2	X No			X No spec		(tiodii, dio.)		African	American
ours aft atural" xamine	g p	15. Decedent's Ed		or Dates:		pleted)	16a. Deceder	nt's Usual	Occupation (Girking life, DO N	ve kind of w	ork done		ind of Business	/Industry
136 thin 72 hours after te. than "natural", edical Examiner	Completed	Elementary/Seco	ondary (0-12)	Colleg	ge (1-4 or 5	i+)	Nurs		,,,,,,g		,	He	althcare	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name		, Last)					1		(First, Middle, I	Maiden S	Surname)	
2121 uld be fi Mental marked	To Be	Nathan 19a. Informant's Na)				(Street and I		ural Route Nur			
MD nd 2 sho alth and m 27 is	L	Johnnie I		nes-Daug	hter	206			er Dr.,		ict Hei		ocation - City o	
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, the		1 X Burial 2	Cremation		al from Sta	ate (crematory or of lter's	ther place)	l l	12-07		lter's	
altim mit Pa partmer portani	+	Donation 5 21. Signature of Fu				100.	22.	Name and	Address of Fac					neral Home
m ឱ្ងឹ≣ឱ Physician	-	Sa. Part I. Enter th	ne disease, or	complications th	nat caused	the death			28th St.					Approximate Interval
/Medical Examiner	Ĭ	failure, List on Immediate Cause (ly one cause	on each line.					ssociated					Between Onset and Death
Examiner		or condition resulti	ng in death)	Due to (or	as a conse	equence o	f):							
	ner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	Due to (or	as a conse	equence o	rf):							
d	Examiner	(Disease or injury to events resulting in	hat initiated	Due to (or	as a conse	equence o	f):							
ceath certificate be executed eath certificate be executed a attending physician and for use as the burial - transi	Medical E	UNPENDED		d AMEND	ED		<u>-</u> ,							
760, icate be physical the buri	/Med	IF FEMALE: 23b. Was decedent	pregnant in t	bo -	yes, outcor	ne of preg		ملفم جائد امد	3 Ect	opic pregna	incv	230	Date of delive	ery Day Year
Box 687(e death certificathe attending pleed for use as the	/sician/N	past 12 months		4 _ P	ive birth regnant at	time of de	oth =	etal death other (Spe		opic pregne			Mona	54,
& ± & 0	Phys	Part II. Other sign		1000	Inknown ing to deat	h but not r	resulting in the	underlyin	g cause given in	n Part I.	23e. Did t	obacco	use contribute	to the cause of death?
Division of Vital Records, P.O. B rat or attending Physician: The law requires that the drs after death. "In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	d by										19		No 3 Pr	obably 4 Unknown autopsy findings available
cords law request beer 2 should	ompleted					-	· · · · · ·					psy orm <u>ed</u> ?	prior to death	completion of cause of
l Re(n: The Tificate or, page	O	25. Was case refe	rred to medic	al					26.Place of De	ath (Check	1 Yes	2 N	0 1 🗸	Yes 2 No
Vita hysicia this ce	To Be	examiner?	2 No	Hospital: 1	Inpatio		ER/Outpatier		DOA Other		g Home 5	Reside		ner:
on of nding Pt th. r: After ie funeral	ion:	27. Manner of Dea		28a. nding	Date of Inji Month, Day,	ury (ear)	28b. Time of	injury	1 Yes 2		20d, Describe	TIOW HIJE	ary occurred	
ViSiC or Atte fiter dea Director	Certification:	2 Accident 3 Suicide	6 Co	lia not be	Place of Ir	njury - At h	nome, farm, str	eet, factor	y, office building	g, etc.	28f. Location or Town,		and Number or	Rural Route Number, City
Division of North Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		4 Homicide 29a. Certifier	Cartifulna	Physician: To th	e best of m	v knowled	dge death occ	urred at th	ne time, date an	d place, and	I due to the cau	use(s) an	nd manner as si	tated
To the H within 24 To the F complete	Medical	(Check only one) 2	Medical Ex	aminer:On the b	asis of exa	mination	and/or investig	ation, in n	ny opinion, deat	h occurred a	at the time, date	and pla	ace, and due to	the cause(s)
L × F 5	ž	29b. Signature and	title of certif	ier ()(10			29	O.C.M.E.	iper		1	il 1, 2007	Month, Day, Year)
0 (1)	300	30. Name and add									2125			
100	23. 16	Margarita h						Penn S	treet, Baltim	ore, MD	21201			
S	tate	31. Date filed Mo	15°200	A.	. registi	A. Signal	Tied !							

			For State Registrar	State of Man		artment of H			ene g. No: 0 0 7	12690
			Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ALMA	RHYI	MES			APRIL	1 2007	10:15 P ^M
	Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or	Location of De	ath	4c. County of Death	
			CHERRY LANE N			LAUR			PRINCE G	
	Funeral		5. Social Security Number 261-22-7619	6. Sex 7. Age (III	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Y13910 FLOR	place (State or Foreign TDA
	Director		Usual Residence of Decedent		110.					
	land ow		10a. State 10b. County	10	C. City, Town or Lo	cation				10d. Inside City Limits
	Mary Ff sh	ţ	MD PRINCE	E GEORGE'S	GLEN	ARDEN				1 XYes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	th wit	alD	8618 MCLAIN	AVENUE			20706		U.S.A.	
	ems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
36	ours after death with the Marylan rel', or items 23e or 28e-f show Exertirer must be nutified at	Бу Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2₹☐XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	BLACK
8	72 hours after death with the Maryland "naturel", or items 23a or 28e-f show dical Exertiner must be multified at	ed b	15. Decedent		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/I	ndustry
5	s within 72 plene. r then "na ire Medic	plet	(Specify only highes Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of v i)	working		
212	d within glene. er then "	Completed	9th	College (1 401 51)	НО	ME MAKER			PRIVAT	E
n	be filed ital Hygis od other event, ti	Be (17. Father's Name (First, Middle,	Last)			18. Mother's N	Name (First, Middle, N		
yla		ဥ	SAUL BLOCKER					MINNIE	BLOCKER	i- 0- 4-1
Maryland 21215-0036	2 sho		19a. Informant's Name/Relations CALVIN PHILLI					Hurai Houte Number, GLENARDEN, I	City or Town, State, Z	20706
	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic		20a. Method of Disposition		20b. Place of Dispo	osition (Name of		_	20c. Location - City or 1	
Baltimore,	0 0	l P	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cre RIVERDA	matory or other plac LE CREMAT	ORY 4/	/3/2007	RIVERDALE,	IARYLAND
Ħ	permit. Pag Dep-rtment Importent: I any injury o		21. Signature of Funeral Server		2:	2. Name and Addres	ss of Facility	I B. JENK	INS FUNERAL	. HOME
ä	permit. Departr Importe any inji		- Or						ER, MARYLANI	
			23a. Part1. Enter the disease, or	complications that caused the						Approximate Interval Between
u	Physician		Immediate Cause (Final disease or condition	RE	CAIR	1.004	FA	KURE	_	Onset and Death
П	/Medical		resulting in death)	Due to (or as a c	onsequence of):	4000		INVIRE		
	Examiner	_	Sequentially list conditions,	b	NGE	SILVE	HE	IRI FA	ILURE	
	be fis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):					
	xecut and II-tran	хап	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burransitians.			L d						
9	tificate og phys as the	Physiclan/Medical								
Вох	eath certific attending pl for use as t	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 (⊒Ectopic pregnancy	,		23d. Date of deli	very Day Year
	the atte	sicla	in the past 12 months?	4□Pregnant at tin		Other (specify)			Month	Day real
P.0	that the ded by the detached	Phy	9 Unknown		- A Maile - 1- Ale		an in Bost I	23a Did tol	pacco use contribute to	the cause of death?
	ires that signed t d be det	by	Part II. Other significant condition	Means contributing to death but i	not resulting in the t	Indenying cause giv	en ar Falti.	1 □ Ye	-1/	
0.0	w requir been si should	eted	10/1/200	1001V	11 Jen			24a. Was a	24h Wara 20	topsy findings available
Records,	e law has t	Completed	H700	THTRO	21 1 3	py		 autops perforr 	ned? prior to death?	completion of cause of
a	icien: Th certificate rector, pag		25. Was case referred to medica				OF Place of	1 ☐ Yes :	2 ⊈No 1 ☐ Yes	2 € No
Vital	Physicien: this certificated ral director,	o Be	examiner?	Hospital:	2 ER/Outpatie	nt 3 □ DOA Oth	00		ence 6 Other (Spec	cify)
o	g Phys er this eral di	 	27. Manner of Death	28a. Date of Injury			v at		ow injury occurred	
ion	Attending For death. sector: After by the funera	atlo	1 Natural 5 Pendir	gation	out, injury		Yes 2 □ No			
Division	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of Injury building, etc.	- At home, farm, st (Specify)	treet, factory, office		28f. Location (SI City or Town	treet and Number or Ru n, State)	ural Route Number,
0	ospitel o hours aff unerel Di iy filled ir		***					lean and due to the o	augusta) and manner as	stated
	Hosp 24 hou Fune Itely fi	edical	29a. Certifier 1 Certifyii (Check only one) Medical	ng Physician: To the best of e Examiner: On the basis of e and manner state	xamination and/or is	th occurred at the tir nvestigation, in my o	ppinion, death o	occurred at the time, d	ate and place, and due	to the cause(s)
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifie			29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)
	F S F Ö) ani	m. mo		1)0	041	-2/2	4/31	07
1	(2)		30. Name and address of person	who completed cause of dea	th (Item 23a) (Type	, Print)	12	1	, Col	Secre PK
1	()/		ADEBOWA	LE AJAY	1 Ms	6201	CTYE	enself v	1d no	20740
'		ate	31. Date filed (Month, Day, Year,	32. Registrar	Signature					, ,
	Regist	rar	APR 0 5 2007	Milew D.	Maria					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 MARCH 30° 4:15 Рм **EPHIGENIA** RIBEIRO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LARGO MANOR CARE NURSING HOME 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth June 6 1943 Birthplace (State or Foreign Country) **Funeral** 1□M 2QF 056-52-4284 63 Yrs Director BRAZIL Usuat Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. fnside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No PRINCE GEORGE'S BLADENSBURG MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 5201 QUINCEY STREET # 102 20710 U.S.A. *natural', or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after Il Hygiene. other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates; Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) PRIVATE HOUSE KEEPER 6th permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SEBASTIAO PORFIRIO SEBASTIANA PORFIRIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6937 DECATUR STREET HYATTSVILLE, MARYLAND 20784 SIMONE SUTTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 4/7/2007 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Libersee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complication—that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METANTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificete has been signed by the attending physicien and physicien and s the burial-transit ANEMIA Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical use as fF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year signed by the at d be detached to 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 -- No Division of Vital 1 Yes 2 - No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 2 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Natural fnjury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of friury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062116 APRIL 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEKLIT WORKNEH M.D. 7705 BELLE POINT DRIVE GREENBELT, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2007 Registrar

DHMH 17 Rev 1/2001

07-02332 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Pedro Rodriguez Rodriguez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 26, 2007 Year 1456 hrs **Medical Examiner** Pedro Rodriguez 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1252 Danielle Drive Frederick Frederick If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign E1 Months Days Hours Min Director 10/29/1978 621-25-6939 1 X M 2 Country) Salvador 28 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Frederick 28a-f show or items 23a or 28a-f shormast be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1252 Danielle Drive 21703 El Salvador Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Armed Forces White, etc. 2 X No Yes Widowed Divorced If Yes, Give Year 2 No specify: Salvadoran Specify: White traumatic event, the Medical Examiner more, MD 21215-0036
Pages I and 2 should be filed within 72 hours afterent of Health and Mental Hygiene.
not: If item 27 is marked other than "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Mason 4th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pedro Rodriguez æ Rosa Imelda Rodriguez 9b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Landmard Avenue 19a. Informant's Name/Relationship (Type, Print) Jose A. Rodriguez/brother Oxmond. California 93036 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, spartment of He oportant: If its jury or other t crematory or other place) San Miguel, 1 X Burial 2 Cremation 3 Removal from State 04-13-2007 El Salvador Family Cemetery Donation 5 Other Specify. 22. Name and Address of Facility . . . acon uneral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. /Medical a. Hanging Immediate Cause (Final disease) xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed ian/Medical the attending physician ed for use as the burial -UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Fetal death Day past 12 months? Pregnant at time of death Physici Other (Specify) 1 Yes 2 No 9 Unknown detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown page 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 Other₄ DOA Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 Yes ٩ 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self 1 FOLIND: Division Natural Yes 2 V No death. Pending the Mar 26, 2007 1500 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1252 Danielle Drive, Frederick, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1

en Onset and

Year

2 No

29d. Date signed (Month, Day, Year)

March 27, 2007

Death

To the Funeral Director:

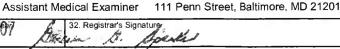
Medical

DHMH 17 Rev 1/2001

OCME 2006

Carol Allan, MD 31. Date Della Month CD2 (1947) State Registrar

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

Karina Marlene Ro		guez S	ate of	Maryla		epartm Certific		Health an	d Ment	tal Hy			21		126	9
Physician	5	tegistrar 1. Decedent's Name (First, Midd	lle,Last)			Certino	arc or	Dodin		2	2. Date of Dea		han w		3. Time of Death	
Medical Examine	.,	Karina Marle		drigu	ez						Month March 26				1546 hrs	
		4a. Facility Name (if not instituti 1252 Danielle Drive	on, give str	eet and nu	mber)		4	b. City, Town, or Frederick	Location o			F	County of rederick			
Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last bir	thday)	If Under 1 Year			8. Date of Bi	rth(MM	(DD/YYYY)	Foreign	place (State or	
Director	2	219-73-5755	1 M	2 X F	1		Yrs.	Months Day	s Hours	IVIIII.	11/13	/200)5	Cour	ntry) Maryla	ınd
Á:		Usual Residence of Decedent 10a. State 10b. County			1100	. City, Town	or Locati	on							10d. Inside City Lim	nits
d how as		Maryland Fred				•	F	rederic	K						1X Yes 2	No
arylan 8a-f si	Director	10e. Street and Number						10f. Zip Code		-		10g. Cit	izen of Wha	at Count	гу?	
tith the Maryland 23a or 28a-f show any notified at once		1252 Danielle	e Dri	ve				2170					J.S.A.			
th with cms 2.	Funeral	11. Marital Status 1 X Never Married 2	12 Married	2. Was Dec	orces?		13. Wa	s Decedent of Hi es, specify Cuba	spanic Orig n, M exican	gin? (Spe , Puerto F	ecify Yes or N Rican, etc.)	0-	14. Race - White		an Indian, Black,	
ter dea			vorced If Y	Yes es, Give Yee	2 X	No	1 X	Yes 2 No	specify:	Sal	vadora	n	Specify: V	Vhit	е	
ours aft	함	15. Decedent's Education (Sp	or	Dates:		ted) 16a.	Deceden	t's Usual Occupa	tion (Give	kind of w	ork done	16b.	Kind of Bus	iness/In	dustry	
6 3.72 ho an "ns	影	Elementary/Secondary (0-12)	College (1	1-4 or 5+)		3		5. DO 1401	use retire	ou,					
OO3 withing giene.	Completed	0 17. Father's Name (First, Middl	e. Last)				non	ie	18.Mother	's Name	(First, Middle,	Maider	none Surname)		-	
21215-0036 Uld be filed within 7 Mental Hygiene event, the Medica	Be	Pedro Rodrigu									Marlen					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medisel Examiner must be notified at once	욘	19a. Informant's Name/Relation				15	b Mailing	andmard	et and Nun Aven	nber or R ue	ural Route Nu	ımber, (City or Town	n, State,	Zip Code)	
md 2 sho salth and em 27 is raumati	-	Jose A. Rodri	guez/	uncı	.e	10)xmon	d, Cali:	corni	a, 9	3036 Date				own, State	-
Baltimore, permit. Pages l ar Department of Hee Important: If ite		1 X Burial 2 Cremati		Removal fr	rom State	crema	itory or ot	her place) letery		04-	13-200					
Iltim nit. Pa artmer oortani	1	4 Donation 5 Other 21. Signature of Funeral Service	Specify: e Licensee			- amily			s of Facilit						me, Inc.	
Dep Dep Injurie	П	Wanda C	180	acon	,CC	36				-			_		.c. 20010	
Physician Medical		23a. Part I. Enter the disease, failure. List only one caus	e on each	line.	aused the	e death. Do r	not enter t	he mode of dying	, such as o	cardiac or	respiratory a	rrest, sr	nock, or nea	art	Approximate Intel Between Onset a Death	
(Examiner	1	Immediate Cause (Final diseas or condition resulting in death)		phyxia e to (or as a	a consequ	ence of):						-			Death	
	- 1	Sequentially list conditions,	b	J (0, 00)												
	힐	if any, leading to immediate cause. Enter Underlying Caus	e c	e to (or as	a consequ	ence of):										
d Sit	Examine	(Disease or injury that initiated events resulting in death) Las		e to (or as	a consequ	ence of):										
and and	edical	UNPENDED	d	MENDED												
60, ate be ex hysician e burial	Medi	IF FEMALE:			outcome	of pregnanc	y			_	_	2	3d. Date of	delivery		
687 certific ding p	jan/	23b. Was decedent pregnant in past 12 months?	the	1 Live		ne of death	-	etal death 3	Ectop	ic pregna	incy		Month	D	ay Year	
Box 6876 e death certificate the attending phy ed for use as the le	Physician/M	1 Yes 2 V No 9 L	nknown	9 Unkr			5 0	ther (Specify)								
tal Records, P.O. Box 6876 cins. The law requires that the death certificat certificate has been signed by the attending phyector, page 2 should be detached for use as the	by Ph	Part II. Other significant cond	litions co	ontributing	to death b	ut not resulti	ng in the	underlying cause	given in P	art I.					the cause of death	
S, P puires t					<u></u>						24a. Wa				topsy findings avai	
cord law rec has bee	Completed										aut per	opsy formed	?	prior to d death?	ompletion of cause	e of
Rec : The ificate		25. Was case referred to medi	not II					26 Pla	ce of Death	(Check	only one)	2	No 1	✓ Ye	s 2 No)
/ital	o Be	examiner? 1 ✓ Yes 2 No		pital:	Inpatient	2 ER/	Outpatien		Other ₄		ng Home 5	Resid	dence 6	✓ Other	: Scene	
n of Vital Rec Jing Physician: The L. After this certificate funeral director, page	\vdash	27. Manner of Death		28a. Date	e of Injury th, Day,Year D:	28t	. Time of		jury at Wor	_ 1	28d. Describ Subject as			red		
ttendi death.	atio	1 Natural 5 Pe	nding estigation	Mar 26	, 2007	15	OUND: 00 hrs		Yes 2 ₩	No				or or Du	ral Route Number,	City
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	de	ould not be termined			y - At home, nhouse / F		eet, factory, office	e bullaing, e	etc.	or Town 1252 Danie	, State) lle Driv	e, Frederi	ick, MD	rai Noble Noriber,	Oity
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier Certifying	Physician	: To the be	est of my k	nowledge, d	eath occu	urred at the time,	date and p	lace, and	due to the ca	use(s)	and manne	r as state	ed.	
To the Hos within 24 h	edical	one) 2 Medical E	xaminer:0	n the basis	of exami	nation and/o	r investiga	ation, in my opini	on, death o	occurred a	at the time, da	te and p	place, and o	due to th	e cause(s)	
00	ĕ	29b. Signature and title of cert	ifier	en					nse numbe	r			d. Date sign arch 27,		nth, Day, Year)	
		lande	_46	ll	du	15 /15		0.0	C.M.E. ———			IVI	ui (11			
2		30. Name and address of pers Carol Allan, MD	on who cor \ssistant) 1 Penn	Street, Baltin	more, Mi	D 2120	1					
Sta		31. Date filed (Month, Day, Yea		32. F		Signature	and	,								
Regist	rar	APR 0 6 20	וטנ	Marc		H. A.	Contract of the last									

ngel Eduardo I		Iguez State of N 1- For State Registrar	laryland / Departmo <i>Certifica</i>	ent of Health an ate of Death	d Mental Hy	/giene Reg	. No.	200	7 1269
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Angel	Rodrigue	ez		2. Date of Death Month [March 26, 2	Day Y	Year 3	Time of Death 1546 hrs
		4a. Facility Name (if not institution, give stree 1252 Danielle Drive	et and number)	4b. City, Town, or Frederick	Location of Death			ty of Death rick	
Funeral Director		5. Social Security Number 6. Sex 212-69-8593 1X м	7. Age (In yrs. last birt	thday) If Under 1 Yes Months Day		8. Date of Birth 12/30/	•	YY) 9. Birthp Foreign Coun	Maryland
япу		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				1	0d. Inside City Limits
	ō	Maryland Frederick	c Fi	rederick					1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 1252 Danielle Drive	2	10f. Zip Code 21703		100	U.S	What Countr	y?
death with or items 2:	Funeral	1 Never Married 2 Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	w	hite, etc.	in Indian, Black,
irs after ural", c	þ	3 Widowed 4 Divorced If Yes or Dr. 15. Decedent's Education (Specify only high	ites:	1 Yes 2 No				fy: White Business/Inc	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		College (1-4 or 5+)	during most of working life none			none	1	·
15-0(filed wi d other d other		17. Father's Name (First, Middle, Last) Pedro Rodriguez			18.Mother's Name	(First, Middle, Marlene			
212' ould be Mental marke ic event	To Be	19a. Informant's Name/Relationship (Type, I	Print) 19	b. Mailing Address (Stre	et and Number or F				Zip Code)
MD nd 2 shc alth and m 27 is		Jose A. Rodriguez/u 20a. Method of Disposition	0	363 Landmard exnond, Cali of Disposition (Name of co	fornia, 9	3036 Date	20c Locatio	on - City or To	own State
imore, Pages I au ment of He tant: If ite		1 X Burial 2 Cremation 3 R 4 Donation 5 Other Specify:	emoval from State cremat	tory or other place) y Cemetery	04-	13-07	San M	Miguel,	, El Salvad
Balti permit. Departr Import		21. Signature of Funeral Service Licensee	Ballan 361	22. Name and Addres					
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	e.						Approximate Interval Between Onset and Death
xaminer			d Injuries o (or as a consequence of):					-	Deau
	La	Sequentially list conditions, if any, leading to immediate Oue to	o (or as a consequence of):					\rightarrow	
	Examiner	cause. Enter Underlying Cause	o (or as a consequence of):		-				
ecuted and transit	al Ex	d							
60, ate be ex hysician e buriat	Medical		ENDED c. If yes, outcome of pregnancy				23d Date	e of delivery	
Sox 68760, teath certificate be executed a attending physician and for use as the burial - transit		23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal death 3	Ectopic pregna	ancy	Mont	_	ay Year
Box death of the atter	Physic	1 Yes 2 No 9 Unknown 9	Unknown	5 Other (Specify)					
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certificar as the death. "al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	by PI	Part II. Other significant conditions cont	ributing to death but not resultin	ng in the underlying cause	given in Part I.				ne cause of death?
rds, Frequires	Completed					24a. Was a		4b. Were auto	opsy findings available impletion of cause of
Recol	omp					perform	ned?	death?	_
tal R cian: 1 certific ector, p	Be C	25. Was case referred to medical examiner?	al:		oe of Death (Check			0 2 00	0
of Vi g Physi Rer this	To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Outpatient 3 DOA Time of Injury 28c. Inj	jury at Work?	28d. Describe h	ow injury oc	6 Other:	Scene
ion (trending leath.	ation	1 Natural 5 Pending 2 Accident Investigation		UND: 1	Yes 2 V No	Subject assa			
Divis al or A s after of al Direct	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At home, f (Specify) Townhouse / R		building, etc.	28f. Location (S or Town, St 1252 Danielle			al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	one) 2 Medical Examiner: On t	o the best of my knowledge, de he basis of examination and/or	eath occurred at the time,	date and place, and	due to the cause	e(s) and mai	nner as state	d. cause(s)
To To Cor.	Me	29b. Signature and title of certifier	manner stated.		se number			signed <i>(Mon</i> i 27, 2007	th, Day, Year)
		30. Name and address of person who comp Carol Allan, MD Assistant M		Penri Street, Baltir	nore, MD 2120)1			
	tate	31. DAPR (NOTE 2007) And	32. Registrar's Signature						
Regis	trar	ATT 1 0 2 2001	en H. Aper	a					

Vanusa Beetriz Rootriguez 07-02331

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ March 26, 2007 1456 hrs **Medical Examiner** Vanesa Beatriz Rodriguez 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick 1252 Danielle Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min Months Country) Mary land Director 04/12/2002 217-63-4450 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County X Yes 2 No Frederick Frederick Maryland or 28a-f show items 23a or 28a-f shovust be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21703 1252 Danielle Drive U.S.A. 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. In journal: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner must injury or other traumatic event, the Medical Examiner must 2 Married White 2 X No 1 X Yes 2 No specify: Salvadoran Specify. If Yes, Give Yaar Widowed Divorced á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 none none pre-k 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daysi Marlene Benitez Be Pedro Rodriguez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Landmard Avenue Oxnond, California, 93036 19a. Informant's Name/Relationship (Type, Print) ۵ Jose A. Rodriguez/uncle 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place San Miguel, 1 X Burial 2 Cremation 3 Removal from State 04-13-2007 El Salvador Family Cemetery Donation 5 Other Specify: 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3447 14th Street, N.W. Wash., D.C. 20010 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Medical Death a Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED physician the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year attending j for use as ti Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>δ</u> 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? page 2 ✓ Yes 2 No 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 ___ Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA ۵ 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Medical Certification: Subject asphyxiátéd FOUND: 1 Natural 1 Yes 2 V No Pending To the Funeral Director: completely filled in by the Mar 26, 2007 1500 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 1252 Danielle Drive, Freederick, MD Suicide determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) APR 0 6 200 32. Registrar's Signature

ORIGINAL

Registrar

Elsa Albertina Rodriguez Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea, No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Year March 26, 2007 1546 hrs Medical Examiner Elsa Albertina Rodriguez 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Frederick 1252 Danielle Drive Frederick Birthplace (State or Foreign F. 1 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director 03/25/1998 Country) Salvador 8 214-65-1308 M 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Frederick 1 X Yes 2 No Maryland Frederick 28a-f show the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1252 Danielle Drive 21703 El Salvador Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23, or other transmatic event, the Medical Examiner must be no Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. White, etc. Armed Forces 1 X Never Married 2 Married Yes 2X No White 1 X Yes 2 No specify: Salvadoran If Yes, Give Year Divorced Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 none none 3rd 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daysi Marlene Benitez Be Pedro Rodriguez 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Landmard Avenue 19a. Informant's Name/Relationship (Type, Print) Jose A. Rodriguez/uncle Oxmond, California 93036 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, San Miguel, tant: If it crematory or other place) 1 X Burial 2 Cremation 3 04-13-2007 El Salvador Department Family Cemetery Other Specify: Donation 5 22. Name and Address of Facility W.H. Bacon Funera Home, Inc. 21. Signature of Fungfal Service License 20010 3447 14th Street, N.W. Washington, D.C. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 ✔ No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? icate has been signed by page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 No Yes 2 No To the Hospinal or Attending Physician: 'within 24 hours after ceath.

To the Funeral Director: After this certific completely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Medical Certification: Subject asphyxiated FOUND: Natural Division Yes 2 V No Pending Mar 26, 2007 1500 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 1252 Danielle Drive, Frederick, MD determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated

111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 27, 2007

07-02656 Harold Wallace Rol		te of Maryland / De	partment of	Health and I		egible. 200	7 12697
	Registrar		Certificate of	Deam	lo pete et p	Reg. No.	
Physician/ Medical Examine	Harold	Wallace	_	Roberts	2. Date of D Month April 7,	Day Year 2007	3. Time of Death 1610 hrs
	4a. Facility Name (if not institution Prince George's Hospit			b. City, Town, or Loc Cheverly	ation of Death	Prince Georg	
Funeral Director		5. Sex 7. Age (In yr	rs. last birthday) Yrs.			5/1952 Fore	Birthplace (State or eign Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. County		City, Town or Locati				10d. Inside City Limits
the Maryland a or 28a-f show Lifted at once. Director	Maryland Cha	rles	Bryanto	10f. Zip Code		10g. Citizen of What Co	1 Yes 2 X No
ith the M. 23a or 2. notified		ry Drive	n II S 13 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	20617-	2003 sic Origin? (Specify Yes or	U S A	erican Indian, Black,
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Mar	ried Armed Forces?	o If Y	es, specify Cuban, M	exican, Puerto Rican, etc.)	White, etc.	White
hours afte natural"; sxaminer	3 vvidowed 4 Divo		i) 16a. Deceden	Yes 2 X No sit's Usual Occupation ost of working life. DO	(Give kind of work done	Specify: 16b. Kind of Busines	
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Senio		Technician	Mira	nt
215-0 be filed v mtal Hygin riked othe ent, the 2	William		erts, Jr.		Mother's Name (First, Middle Edna	Mae C	ooksey
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	19a. Informant's Name/Relationsh Shirley Roberts				ry Drive, Br		
Baltimore, MC permit. Pages I and 2 st Department of Health an Important: If item 27 injury or other trauma	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	crematory or oth			20c. Location - City	
Saltim ermit. Pa epartmen mportant ijury or o	4 Donation 5 Other Spe 21 Signature of Funeral Service L		22 1	s Episcopa ame and Address of rinsfield-	Facility		le, Maryland
Physician	25a. Part I. Enter the disease, or of failure. List only one cause of	omplications that caused the de	eath. Do not enter the	0195 Three ne mode of dying, suc	Notch Rd.,	Charlotte H arrest, shock, or heart	A all, MD 2062: Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence	ce of):				Death
e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	ce of):	· · · ·			
executed an and al - transit ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.	ce of):		· · · · · · · · · · · · · · · · · · ·		
		AMENDED				23d. Date of deliv	Any
Division of Vital Records, P.O. Box 68760, within 19 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification. To Re Completed by Physician/Medical Exhodical Certification.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	4 Pregnant at time o	2 Fe	tal death 3 her (Specify)	Ectopic pregnancy	Month	Day Year
P.O. I so that the gned by the detache		ons contributing to death but n	not resulting in the u	inderlying cause give		id tobacco use contribute Yes 2 ✔ No 3 P	
Division of Vital Records, P.O tall or Attending Physician: The law requires that it after death. **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detached in by the funeral director. Page Completed by Fortification: To Re Completed by Fortification.					pe		
Rec Fiftcate Port, page				26. Place of	Death (Check only one)		
Vital Physician: this certified director,	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Ott	ner Nursing Home 5	Residence 6 Ot	her:
on of \nding Phy th. r: After the funeral	27 Manner of Death	28a. Date of Injury (Month Day, Year) Apr 7, 2007	28b. Time of I 1315 hrs	njury 28c. Injury a	 Subject r 	be how injury occurred inned by rail car(s)	
Division o spital or Attending nours after death. neral Director: Aft (filled in by the fune	2 \(\subseteq \) Accident Inves 3 \(\subseteq \) Suicide 6 \(\subseteq \) Could determ	not be nined (Specify) Other (s			or Tow	on (Street and Number or n, State) alk Point Road, Eagle	Rural Route Number, City Harbor , Md.
Divisior Divisior To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the indical Confification		ysician: To the best of my knowniner: On the basis of examination	wledge, death occu	rred at the time, date	and place, and due to the o	cause(s) and manner as s	tated.
To the He within 24 To the Fu completel		and manner stated.		29c. License r	umber	29d. Date signed () April 8, 2007	
	30. Name and address of person					April 0, 2007	
* (0)	Tasha Greenberg MD.	Assistant Medical Ex		Penn Street, Ba	altimore, MD 21201		
Stat Registra	N D D 7	1 2007 32. Registrar's Sig	grature	out _			

07-02656

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Maritan E. 21122 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Chief US Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Will Ross Elvie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbi Beck/Granddaughter 1940 North Avenue, Pasadena, MD 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition April 12. Brinsfield-Echols Crem. olace) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility once. ory M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension - Uncontrolled
Due to (or as a consequence of): /Medical Examiner Inoperable Abdominal Aortic Aneursym Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Coronary Artery disease Due to (or as a consequence of): Physician/Medical Chronic obstructive pulmonary disease IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed dementia with depression 24a. Was an autopsy performed? Yes 2 No 1□ Yes Azotemia 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 Tes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Walder Finds 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) 2070 Old Line Ctr. 20602 31. Date filed (Month, Day, State 3 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:05 Warren Gordon Ross 10 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's 7. Age (In yrs. last birthday) 85 Yrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**X**□M 2□F Director 1921 415–14–2687 31. Tennessee Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director <u>Maryland</u> Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1940 North Avenue 14. Race - American Indian, Black, White, etc.

Charlotte Hall, MD

Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 10:30 Allen 12, 2007 April Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 20826 Waterside Drive Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 218-09-0420 87 Yrs Director August 26, 1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Maryland St. Mary's Director Leonardtown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 20826 Waterside Drive 20650 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Granruth Minnie Mary Daley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Elaine Rush / Daughter 20820 Waterside Drive Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 18, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Olivet Cemetery McGaheysville, Virginia Mt 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Box 270 Leonardtown, MD 20650 P.O. Part1. Enter the disease shock, or heart failure. e, or complication List only one ca ons that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ② No Month Day Year 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 PNo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 M Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cay e of death (Item 23a) (Type, Print) James P. Jarboe, M.D. Hollywood, MD 20636 24035 Three Notch Road 31. Date filed (Month, Day, Year) 321/Registrar's Signature State Registrar **APR 13**

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			tificate of Death		Reg. No. 2007	12700
Physicia Medical Exami		Decedent's Name (First, Middle, Last) Solymar Rodrigue Solymar Rodrigue	z Torres	2. Date of De Month April 13,		3. Time of Death 0722 hrs
		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Glen Burnie	Location of Death	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia		r If Under 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9 Bird Foreig	n
		Usual Residence of Decedent	Yrs	08/2	7/1993 Pa	merto Rico
yland -f show any once.	Ļ	MD	Town or Location len Burnie			10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 642 Hallmark Drive Apt.T-3	10f. Zip Code 2106		10g. Citizen of What Cour	ntry?
15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 12. Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.) Puerto Rican	White, etc.	
nours after natural", o 'xaminer'	à	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 X Yes 2 No 16a. Decedent's Usual Occupat during most of working life.	specify: ion (Give kind of work done	Specify: W1	nite
0036 within 72 hours afterene. rer than "natural", Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Student		Fducati	on
	Be Co	17. Father's Name (First, Middle, Last) Jose Rodriguez Cruz		18.Mother's Name (First, Middle, Vanya Torres		
sho sho	의	19a. Informant's Name/Relationship (Type, Print) Vanya Torres/Mother		t and Number or Rural Route Nu ark Drive Apt		
- P # E #			Place of Disposition (Name of cen RMA FOTH Dace DE rdine Del Ebe	netery, Date	20c. Location - City or	
Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Fundral Service Licensee	PHILIP D	RÎNALDI FUNE	ERAL SERVI	CE,P.A.
Physician	\dashv	23a. Part VEnter the disease, or complications that caused the death. failure. List only one cause on each line.	19241 Coli	<u>ımbia Blvd.Si</u>	<u>lver Spri</u>	pproximate Interval Between Onset and
/Medical Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a. Cardiac arryhtmiz				Death
2.7	-	Sequentially list conditions, if any leading to immediate Due to or as a consequence of				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last):			
executed an and al - transit		d	F 067 F 10 107 F	-		
760, ficate be exe g physician a the burial -		IF FEMALE: 23b. Was decoded proposal in the	nancy		23d Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Physician/	past 12 months? 1 Ves 2 No 9 V Unknown 1 Unknown	2 Fetal death 3 ath 5 Other (Specify)	Ectopic pregnancy	Month D	ay Year
P.O. Boes that the deat	à	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause g		obacco use contribute to	
Division of Vital Records, P.C rate or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed be led in by the funeral director, page 2 should be detail	Completed			24a. Was		topsy findings available ompletion of cause of
tal Reco		25. Was case referred to medical	26 Place	of Death (Check only one)		s 2 No
Vital F Physician: r this certifi	To Be	Tes 2 No		Other Nursing Home 5	Residence 6 Other	
ion of tending Pheath.		27. Manner of Death 1 X Natural 5 Pending (Month, Day, Year)		y at Work? 28d. Describe	how injury occurred	
Divisi pital or Att ours after de eral Direct filled in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At ho	ome, farm, street, factory, office b	uilding, etc. 28f. Location or Town,	(Street and Number or Ru State)	ral Route Number, City
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination are				
y To vit	Me	29b. Signature and title of certifier	29c. License		29d. Date signed (Mor	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item		vi. 🗅 .	April 14, 2007	
	2012	Patricia Aronica-Pollak MD. Assistant Medical E 31. Date filed (Month, Day, Year) 32 egistrar's Signatu		reet, Baltimore, MD 2120)1	
St Regist	ate trar	31. Date filed (Month Day, Year) 2007 32 registrar's Signatu	* Aparle			

		_	For State	State of Ma		partment of H e <i>rtificate of L</i>			ene g. No.2 A A T	7 127	n I
9	-		Registrar Decedent's Name (First, Middle,	Last)				Date of Death Month		3. Time of De	eath
	Physicia /Medic		Helene Marie Ro	oss					30, 200	7 4:12	а м
	Examin		4a. Facility Name (If not institution,	give street and number)			Location of Death		4c. County of De	eath Arundel	
		- 12	Mandrin House 5. Social Security Number 6	S. Sex 7. Age	e (In yrs. last birthda	Harwo	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or F Country)	-oreign
	Funeral Director		152–16–5112	1□M 2⊠F	81 Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 5		Country) New Jersey	
1 2	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c, City, Town or	ocation				10d. Inside City I	
	fanyla shoved at	ō		Arundel	7.	ma Park				1 ☐ Yes 2	
	the N	rect	10e. Street and Number	ander .	00,001	10f. Zip Code		10	0g. Citizen of What	Country?	
	th with 23a or ist be	a D	845 Cottonwood	Drive		2	1146		US		
36	be filed within 72 hours after death with the Maryland thyglene. All Hyglene. ad other than "natural", or Items 23a or 28a-f show other than "matural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? d 1 ☐ Yes 2√2 N If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⊠ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, thite, etc. White	
215-0036	hin 72 hou e. an "natura Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Gi	cedent's Usual Occup we kind of work done of DO NOT use retired	durina most of work	ing	16b. Kind of Busine		
7	filed within Hygiene. other than "ent, the Med	8		2		Secreta			Law Fir	<u>m</u>	
Maryland	should be filed and Mental Hygi s marked other umatic event, t	To Be	17. Father's Name (First, Middle, L. Michael Walcza	•			18. Mother's Name	Michael			
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationshi Janet R. St. M			illing Address (Street 5 Mason F		t Winst	on, GA 30	0187	
altimore,	Pages 1 ann of He ann of He ann or other or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery, c	position (Name of rematory or other place phen's Epi ch Cemeter	<i>:e)</i> ¦ ∆r	oril 3,	20c. Location - City Crownsv		
Balt	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Li	icensee FALCA		22 Name and Addre	& Sons, F	.A. Sev Wy. Sev	verna Parl verna Parl	k Funeral k, MD 2114	Home 16
			23a. Part 1. Enter the disease, or conshock, or heart failure. List o	complications that caused only one cause on each lin	I the death. Do not e	enter the mode of dyir	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Betwe Onset and De	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		ancer				3 mont	
	/Medical Examiner		resulting in death)	Due to (or as	a con a quence of):						
	25.0	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):						
	scuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с							
60,	icate be executed physician and s the burial-transit	E E	resulting in death) cast	Due to (or as	a consequence of):						
68760,	ficate physi s the I	edical		d							
D. Box (The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	/		23d. Date of Month	delivery Day Ye	ar
ds, P.O	w requires that the been signed by should be detack	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	e underlying cause giv	en in Part I.	23e. Did tot		te to the cause of dea	
Records,	The law requirate has been page 2 should	Completed						24a. Was a autops perforr	sv prior	e autopsy findings av to completion of cau h?	/ailable use of
Vital	ician: Th certificate rector, pag		25. Was case referred to medical				26 Place of Dea	1 Yes : th <i>Check onl on</i>	2 No 1 🗆	Yes 2□No	
5	ysician: is certific director,	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpa	tient 3 DOA Oth				Specify) Hosp:	ice
Division or	Attending Physician: or death. ector: After this certifica by the funeral director, p	ıtion: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigs			y Wo			ow injury occurred		
Divis	al or Attend after death.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homlcide determin	and Zoe, Flace Of III]	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Si City or Town		r Rural Route Numbe	er,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical C	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	g Physician: To the best Examiner: On the basis of and manner st	of examination and/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occu	, and due to the c rred at the time, d	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	wen M	0	-	2830		29d. Date signed (M March 30	0,2007	
•	5		30. Name and address of person values of	who completed cause of c	death (Item 23a) (Type 900 BS+	pe, Print)	1 #300	Annas	oslis, MD	2140/	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 4	2007 32 egistr	rar's Signature	hart)			·		

State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 3, 2007 **Physician** 11:15A M Roland Newell Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Center Laurel 8. Date of Birth (Month, Day, Feb 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. $\overset{\scriptscriptstyle{(Pear)}}{19}18$ 1 X M 2 □ F North Carolina 255-10-5525 89 Feb Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2 ZANo Directo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ral", or items 23a or Examiner must be r 9242 Crazy Quilt Court 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Date WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural" I Hygiene. other than "natur rent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Communication Senior Engineer ?7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Annie Mae Rawls Oliver Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9242 Crazy Quilt Ct. Columbia, MD 21045 Ouida Richardson/wife Health a other Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 04/06/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign was of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s performed? Yes 2 X No 2 No 1 ☐ Yes or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Tes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 □ Pending investigation (Month, Day Year) Injury 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital e Funeral 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 5, 2007 D51051 10+1 EUI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3621 Ligon Road Ellicott City, MD 21042 Andres Salazar, M.D. 31. Date filed (Month, PR Ypar)6 32. Régistrar's Signature State 2007 Muse Registrar

07-02554

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerardo Roque	R	- For State egistrar	ate of Ma	ryland / C	-	ment of ficate of		nd N	Menta	ıl Hyg	giene	Reg No	.200)7	12703
Physician Medical Examine	.,	Decedent's Name (First, Midd GERARDO RO		•						2	Month April 3, 2	eath Day			3. Time of Death 1517 hrs
	4	4a. Facility Name (if not institution 16700 Barnsville Roam		nd number)		4	b. City, Town Boyds	or Loc	cation of I	Death	,		4c. County o		
Funeral Director		5. Social Security Number 212-67-8410	6. Sex		n yrs. last	birthday) Yrs.	If Under 1 Months [-	If Under :		8 Date of AUG			Foreign	nplace (State or n intryMEXICO
w any		Usual Residence of Decedent 10a. State 10b. County MD MON'	rgomer	1	•	own or Location	on								10d. Inside City Limits 1 Yes 2 No
Maryland r 28a-f show any	Director	10e. Street and Number 16700 BARNES				100	10f. Zip Cod			······			atizen of Wh		
	= ⊩	11. Marital Status 1 Never Married 2 M	12. Was	s Decedent Evened Forces?	er in U.S.		Decedent of es, specify Cu	Hispan					14. Race White	- Americ	can Indian, Black,
"natural", o	⋧┞	3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)	orced If Yes, Giv or Dates: cify only highes	ve Year		6a. Decedent		pation		nd of wo	rk done	16b	Specify: . Kind of Bu	WH I	
-0036 d within 72 giene ther than The Medical	Completed	6 77. Father's Name (First, Middle				FARME	R	18.	M oth e r's	Name (First, Middle		ORSES		
21215-0036 and be filed within 7 I Mental Hygiene in event, the Medica	Ř	AGUSTIN ROQ)	19b. Mailing	Address (S								MONREAL Zip Code)
, MD shot and 2 shot ealth and cem 27 is traumatic		JOSE JESUS RO	OQUE/B	ROTHER			0 BAR	NES	VIL	LE		ВО		MD	20841
Baltimore, M Permit, Pages and 2 Department of Health is Important: If item 27 njury or other traum		1 Burial 2 Cremation 4 Donation 5 Other S	pecify:	oval from State	сге	matory or oth FELI	er place)			4/1	6/07	s	AN FI	ELIE	PE, MEXICO
Balt permit Depart Impor injury	- 1	21. Signature of F er I Se ice 23a Part I. Enter the disease, or	11			н	ame and Add ILTON O B	FU	INER	AL BA	HOME RNES	VIL	LE, N	4D	20838
Physician /Medical Examiner		23a Part I. Enfer the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Hangin	g		o not enter th	e mode of dy	ng, suc	ch as car	diac or i	respiratory	arrest, s	shock, or he	art	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate	b	r as a consequ											
ed Isit	튑	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	r as a consequ				_						_	
	edical	UNPENDED	dAMENE	DED											
	žΙ	IF FEMALE: (3b. Was decedent pregnant in topast 12 months?) 1 Yes 2 No 9 Un	he 1 1	yes, outcome Live birth Pregnant at tim death Unknown		2 Fel	al death ner (Specify)	3 🔲	Ectopic p	oregnan	су		23d. Date of Month		day Year
ires that the designed by the	by Ph	Part II. Other significant condi			ut not resi	ulting in the u	nderlying cau	se give	n in Part	1.					the cause of death?
cords law requ has been 2 should	Completed											itopsy informed	i5 (Were au prior to d death?	topsy findings available completion of cause of
Vital Recysician: The his certificate director, page	8	25. Was case referred to medical examiner?	Hospital:	Inpatient	2 □ F	R/Outpatient			Death (C		nly one) Home 5	Res	idence 6	✓ Other	Scene
ion of Vil tending Physic eath for: After this	tion: To		ding FO	Date of Injury (Month, Day,Year (UND: r 3, 2007) 2	8b. Time of I	njury 28c.		at Work?				injury occurr i self	ed	
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 V Suicide 6 Cou	ld not be 28e	Place of Injury	y - At hom		et, factory, off	ce build	ding, etc.	- 1	or Town	n, State			ral Route Number, City
To the Hospital within 24 hours. To the Funeral completely filled	ledical C	29a. Certifier 1 Certifying F	Physician: To the												
T S S S S S S S S S S S S S S S S S S S	¥.	29b. Signature and title of certification		0 0 a	0 //		29c. Lie	ense n					d. Date sign pril 4, 200		nth, Day, Year)
4	-	30. Name and address of perso Carol Allan, MD As	n who completed			3a) 11 Penn \$	Street, Bal	timore	e, MD	21201			***		
Sta Registr	ite	31. Date filed (Monta PRYe)		32. R distrar's		b A	ach								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:35 PM Arnold Stokes 30th 2007 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville 54th Place Prince George If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 6 Days Hours 1954 DC Yrs. 579-74-6623 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or Nerrs 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or leans 23a or 28a-f sho traumatic event, the Madical Examinar must be notified at Md Hyattsville 1- Yes 2 □ No Director Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5004 54th Place 20781 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black <u>≨</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Verizon Technician 12th permit. Pages 1 end 2 should be file.
Department of Health and Mental Hyg.
Important: If them 27 is marked other any injury or other traumer. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Brown Arthur Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5004 54th Place Hyattsville Maryland 20781 Francena Stokes(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 04-06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem Riverdale Maryland 4 ☐ Donation 5 ☐ Other (Specify) DC 20011 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Tyrone J. Young 719 Kennedy St.NW Wash 23a. Part1. Epur the disease, or complications shock, in neart failure. List only one not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Cancer of Lung Examiner Due to (or as a consequence of): Examiner igned by the ettending physicien end be detached for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔯 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed this certificete has 1 ☐ Yes 28 No 1 □ Yes 2 □ No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐No 28c. Injury at Work? Certification: 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred efter deeth. Director: After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ò To the Hospital of within 24 hours e To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 03,2007 D23743

State Registrar

Martin Weltz, MD.
APR 0 5 2007

7525 Greenway Court Drive Greenbelt Maryland 20770
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

		1 - State Registrar Amend# s4a.4c.	State of Maryland PerPhys.PC4-5-07				Reg	g. No.	12708
Physic /Medi		1. Decedent's Name (First, Middle, Last					2. Date of Death Month 03	Day Yea 30 200	- 1 200
Examí		4a. Facility Name (If not institution, give	street and number) rge's Hospital	Ctr.		Location of Death		4c. County of De	George's
Funeral Director	4	210-22-1485	x ☐ M 2 XF 7. Age (In yrs. In 79	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Apr. 24,	^{9. E} 1927 Ma	Birthplace (State or Foreig Country) ryland
within 72 hours after death with the Maryland ene. ene. "natural", or frems 23a or 28e-f show than "natural" or frems 23a or 28e-f show the Mcdiral Examiner must be natified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		, Town or Lo	ellville				10d. Inside City Lim 1 ☐ Yes 2X1
23a or 2	ai Dir	10e. Street and Number 10450 Lottsford I	Road Apt. 20	2	10f. Zip Code 207	'21	109	g. Citizen of What USA	Country?
irs after dea il', or iteme xeminer mi	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Spi	ecify Yes or No- Rican, etc.)		
permit. Pages 1 and 2 should be lied within 72 hours affer death with the Maryla Depertment of Health and Mendal Hygiens. Depertment of Health and Mendal Hygiens institutely, or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar multi-be notified at 2008.	Completed	15. Decedent's Edu (Specify only highest grad	ucation	(Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	furing most of work)	ing 16	Sb. Kind of Busine	ss/Industry
z snoud be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	Be Co	12 17. Father's Name (First, Middle, Last)			ce Presid		e (First, Middle, Ma	Banking alden Sumame)	
should to nd Ment marked imatic of	To	Louis W. Kutsch 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailin	g Address (Street a		n R. Kies		Zin Code)
and 2 s ealth ar m 27 ls ner treu		Deborah Fisher / r	niece	9016	Columbine	Ln. U	per Marl	boro, MD	20772
ages and of Hart: If item		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	metery, cren	sition (Name of natory or other place	э)		Oc. Location - City	
permit. Pages 1 and 2 Depertment of Health a Importent: If item 27 Is any injury or other tree		21. Signature of Funeral Service Licens	1.0.	22	ln Cemete .Name and Addres 512 NW Cr	s of Facility Bea	all Funer Bowie	al Home	, мр. 20715
Physician Medical Examiner business and place streets and place streets are the private streets and place streets and place streets are the private streets and place streets are the place streets and place streets are the place streets and place streets are the place streets and place streets are the place	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence. Due to (or as a consequence.	ence of):	ar the mode of dying	g, such as cardiac d	or respiratory arres		Approximate Interval Between Onset and Death
e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
and law requires trat the state has been signed by the page 2 should be detached.	by	Part II. Other significant conditions conheart faulum	ntributing to death but not resu	Iting in the un		n in Part I. Xuseaso		. /	to the cause of death? Probably 4 □Unknow
certificate has be rector, page 2 sh	Completed	U	,				24a. Was an autopsy performe	prior t	
<u>v</u> 0	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ★Inpatient 2 ☐ E	R/Outpatient	3□ DOA Othe	r.	n <i>Check only</i> one) me 5 ☐ Residen		pecify)
After fune		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at :	28d. Describe how		
within 24 hours after death. To the Funerel Director: A completely filled in by the ft	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
within 24 hours a To the Funerel C	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurr	and due to the cau ed at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	2	29b. Signature and filled el certifier			29c. License	number	290	d. Date signed (Mo	nth Day Year)
To the	Σ	29D. Signature and the Common			→ →	990		2012/10/10 1941	20785

07-027	712		
Bryan	Lee	Stump	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

13	0	4	- 9		1	mg	0	900
2	1 1		1	-	2	- 1		
6. 00	~	-	1	- 2	Longo	ă.	0	-

		1- For State Registrar		Certific	cate of	Death				g. No.	(V -	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, La: Bryan Lee Stu	mp						2. Date of Deat Month April 9, 20	Day 07	Year	3. Time of Death 1842 hrs
,		4a. Facility Name (If not institution, gir Civista Medical Center	e street and number)		4	b. City, Town, La Plata	or Location o	f Death		Cha	ounty of Deat Irles	
Funeral Director			7. Age ((In yrs. last bi	rthday) Yrs.	If Under 1 Y	ear If Unde ays Hours	r 24Hrs. Min.	8. Date of Bird Septem	ber ₁₉	9. Bi Forei 94	rthplace (State or gn puntryMaryland
imore, MD 21215-0036 Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It and "filem 25 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral Director	15. Decedent's Education (Specify of	Place 12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	ver in U.S. No leted) 16a	13. Was If Ye 1 Decedent	10f. Zip Code 2066	Hispanic Original, Mexican, Mexican, No specify: pation (Give F	Puerto I	ecify Yes or No Rican, etc.)	US - 14.	Race - Ame White, etc.	ncan Indian, Black,
MD 21215-0036 d 2 should be filed within 72 Ith and Mental Hygiene. n 27 is marked other than "	Completed	Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Las		´	tuden	t	18.Mother	's Name	(First, Middle, I			mallwood
215 be file ntal Hy rked o	B B	Walter Lee Thom					Laura	a Ly:	nn Stum	ıp		
21 should is mal	ျဉ	19a. Informant's Name/Relationship (Type, Print)	1:		,			tural Route Nur	•		
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		Linda Stump/gra 20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place	of Disposi	tion (Name of	cemetery.		Mechan Date April			MD 20659 or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter njury or other tra		4 Donation 5 Other Specif	y:	Char]		erplace) emoria]		ens	16, 200	7 Lec	onardt	own, MD
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service Lice	Mol Moc	174	30	195 Thi	ree No	tch	Rd., Ch	arlot	tte Ha	H., P.A. 11, MD 20622
Physician Medical Examiner	8 5	23a. Part I Anter the disease, or comfailure. List only one cause on a Immediate Cause (Final disease	ıplicatio,श≶ t h ét caused th	ne death. Do i	not enter th	e mode of dyli	ng, such as c	ardiac or	respiratory arr	est, shock,	, or heart	Approximate Interval Between Onset and Death
) -	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a consequence of the consequence of t	quence of):								
760, icate be executed physician and the burial - transit		UNPENDED 2	AMENDED #1, perME, g8	67 5/1/0								
OX 68 eath certif	iciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown	e of pregnanc	2 Fet 5 Oth	ner (Specify)	3 Ectopia			M	Date of deliver	Day Year o the cause of death?
ords, P.O. B w requires that the d sbeen signed by the should be detached	ğ	Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying caus	e given in Pa	art I.		s 2 🗸 N	No 3 Pr	obably 4 Unknown
Reco The lar icate ha	Completed					00 D	ace of Death	7041	1 🗸 Yes	rmed?	prior to death? 1	
Vital hysician: this certif	B B	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatien	t 2 🗸 ER/	/Outpatient		Other ₄	_	g Home 5	Residenc	e 6 Oth	ner:
	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea Apr 9, 2007	y 28t	o. Time of It 35 hrs	· · _	njury at Work		28d. Describe bicyclist str			icle
W 7 0 0 5	Certification:	2 Accident Investigat 3 Sulcide 6 Could not determin	ot be 28e. Place of Inju		, farm, stree	et, factory, offic	e building, e	- 1	28f. Location (or Town, S MD Rt 6 at B	State)		Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge, d ination and/o	death occur or investigat	red at the time ion, in my opin	, date and pla ion, death oc	ace, and courred a	due to the cau it the time, date	se(s) and r and place	manner as st , and due to	ated. the cause(s)
To To	Ĭ,	29b. Signature and title of certifier	and manner stated.			29c. Lic	ense number			29d. Da	te signed (N	fonth, Day, Year)
		Journal C	o completed cause of de	ath (Item 23a	a)	0.	C.M.E.			April	10, 2007	
76		Tasha Greenberg MD.	Assistant Medical			Penn Stree	et, Baltimo	ore, MD	21201			1
S Regis	tate strar	31. Date filed (Morth Pry, Year)	2007 32. egistrar's	s Signature	And the	all of						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** March 27, Alfred Sybot 2007 12:40 a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 XM 2 ☐ F Yrs Director 579-46-4561 Dec. 11, 1930 Washington, DC 76 Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Director Silver Spring 10f. Zip Code Maryland Montgomery the 10g. Citizen of What Country? 10e. Street and Number death with 23a 20902 Funeral 901 Arcola Avenue United States Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items e filed within 72 hours after dial Hygiene. other than "natural", or item 1 TYes 2 No 1950— If Yes, Give Year or Dates: 1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No **Black** þ 3 Widowed 4 Divorced 1955 Completed 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving College (1-4or 5+) Elementary/Secondary (0-12) and Printing permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any Injury or other traumatic event, the I Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Sybot Beulah Atkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 D Street, NW, Ste. 300, Washington, DC 20004 Bruce M. Cooper/Conservator 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Fort Lincoln Crematory Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the dentities Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the s detached t ☐Yes 2☐No 9□Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 No 1 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director: Amer this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Inpatient 27. Mapner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D45471 April 2, 2007 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person Yeheysis Negussie Spring Street, Ste. 214, Silver Spring, MD 1111

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 05

2007

ybut Alfrec

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2007

Marcia Goldmark, M.D., 15020 Shady Grove Road, #300, Rockville, MD

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ROBERT OTIS STUART, SR. 2007 APRIL 1:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LA PLATA CHARLES RESIDENCE. 6380 ASHLAND ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JANUARY 22, 1919 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours **™** M 2 □ F Yrs 233-12-9652 88 VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8 6380 ASHLAND ROAD 20646 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 1943-If Yes, Give Year or Dates: 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: à 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10TH GRADE College (1-4or 5+) MECHANIC AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN HENRY STUART MARY ELLEN PHILLIPS STUART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONNIE M. STUART / WIFE 6380 ASHLAND ROAD, LA PLATA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY APRIL 13,2007 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenset THORNTON FUNERAL HOME, P.A LYDIA C. THORNION JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nocarcinoma Immediate Cause (Final Colon tde **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred il or Attending Fafter death. 5 Pending investigation 1 ☐ Yes 2 No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At horne, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) and manner stated 29b. Signature, and title of certifier 29d. Date signed, (Month, Day, Year) D0051999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11637 TERRACE DRIVE, SUITE 103, WALDORF, MARYLAND MANISHA JARIWALA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 0 6 2007

Please Type or Prin

int in Black Indelible Ink. Ensure All Copies Are Legib	ile.	
aryland / Department of Health and Mental Hygiene	2007	12710
Cartificate of Dooth	and the last of the	I have I I

		1-For State Certificate Certificate	of Death		4 U U 1	12/10
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) Henry Charles Smit		2. Date of Death Month April 12, 20	Day Year	3. Time of Death 0539 hrs
		Facility Name (if not institution, give street and number) Harford Memorial Hospital	4b. City, Town, or Location of Havre de Grace		4c. County of Death Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours	D.C.	(MM/DD/YYYY) 9. Birth Foreign 20 , 1990 Cou	
	ŀ	Usual Residence of Decedent	rs.			
Ow any		10a. State 10b. County 10c. City, Town or Loc MD Harford Aberdeen	ation		1	10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show	Director	MD Harford Aberdeen 10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho		627 Cindy Ct.	21001		U.S.A.	
leath wit r items 2	Funeral		Vas Decedent of Hispanic Origin FYes, specify Cuban, Mexican, F		14 Race - Americ White, etc.	an Indian, Black,
s after c ral", ou	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	ad at wards alone	Specify: Whit	
2 hours	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kir most of working life. DO NOT us		16b. Kind of Business/In	
0036 within jiene ner thar Medica	Completed	10 Stude		Name (First, Middle, M	Scho	
21215-0036 and be filed within 7 Mental Hygiene marked other than c event, the Medica	BeC	Glenn P. Smit	Melk	oa L. Hoppe	rs	
MD 21 nd 2 should in the and Men m 27 is man	10	· · · · · · · · · · · · · · · · · · ·	ing Address (Street and Numb	er or Rural Route Numb Aberdeen, M		Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Cremation 3 Removal from State crematory or	osition (Name of cemetery, other place) Mem. Gdns.		20c. Location - City or 1 Aberdeen, M	
Baltii permit. Departm Importa		21. Signature of Funeral Service Licensee Visite August 11 August 12 August	Name and Address of Facility Tarring-Cargo Aberdeen, Mar	Funeral H	ome 3399 ^A .	·
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of):			,	Death
	_	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence of):	-			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence of).				
7 60, cate be exe physician a	Medical	XUNPENDED AMENDED #25a,27, perME, g868, 6,	/28/07 TT		23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic potential Control (Specify)	pregnancy		ay Year
P.O. Bo that the deal	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part	I. 23e, Did tok	pacco use contribute to t	he cause of death?
, P.C ires that signed 1	d by				2 No 3 Prob	ably 4 🗸 Unknown
ords w requi as been should	Completed			24a Was a autops perforr	y prior to c	opsy findings available ompletion of cause of
Rec: The la			26.Place of Death (0	1 ✓ Yes 2		s 2 No
Vital ysician his certi directo	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	(Other:		Residence 6 Other	
O Of ding Ph		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	!	ow injury accurred	
Division of Vital Records, P.O. To the Hospital or Attending Physiciau: The law requires that t within 24 hours after death To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s			treet and Number or Rui	ral Route Number, City
Hospital Voneral Poly filled		4 Homicide determined (Specify) 29a Certifier (Check path 1 Certifying Physician: To the best of my knowledge, death or	curred at the time, date and place	ce, and due to the cause	e(s) and manner as state	ed
To the within 2 To the Complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	gation, in my opinion, death occ	urred at the time, date a	and place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Mor April 12, 2007	iiii, ⊅ay, reai)
		30. Name and address of person who completed cause of teath (Item 23a)	,			
		Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature	111 Penn Street, Balt	imore, MD 21201		
S Regis	tate trar	APR 1 9 2007	relied .			

Amend Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-Date . Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Sullivan 0645 rordon 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Anne Arunde Medical Hone Hrundel 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Months Days 49 Director 220-66-4207 10/07/1957 Usual Residence of Decedent 10a State 10c. City. Town or Location. 10h Count 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at Talbot **Easton** Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 West 21601 Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: **Black** Specify: ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cook Crazy Jane's 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be find and Mental Find marked of Sullivan Reginald Nellie Wilson Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 least Injury or other trains once. Larry Sullivan/Brother 112 South Street, Easton, MD 21601 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Richards Memorial Park 03/17/2007 Easton, MD 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home, 426 Dover St., Easton MD 21601 Taumie Y. Shaw per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Embolus Pulmonany **Physician** 10ay /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the e O 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Immunodeficiency Vinus 1 AIDS 1 Yes 2 No 3 Probably 4 Dunknown should failure TIVER HEUROSYPHIL'S IVERILTER MYOMBOSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy Sepors /V
25. Was case referred to medical examiner? perfor 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital To the Hospital or Attending Physicien: within 24 hours efter deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0/852 ORE MD 4203 (Type, Print) Delens bury rel Hyattsville MD 2029

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2007

COBOLE !

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 Year April Day **Physician** Jacquelyn Ε. Tullar 2:20 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 11-17-1947 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Washington, DC 1 ☐ M 2 😿 F 215-52-9124 59 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ∏Yes 2 No MDDirector Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be no pine. 20782 United States 3705 Nicholson Street Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edwin R. Davis <u>Bertha Dodge</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Tullar (husband) 3705 Nicholson Street Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 4/6/2007 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 Dutred 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 🗌 Yes 3 No 3 Probably 4 Unknown Multiple Sclerosis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1x Inpatient funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Hospital 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MIC

State

1500 Forest Glen Road 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver Spring, MD 20910

4/3/2007

DR 63579

31. Date filed (Month, Day, Year)
APR 0 5 2007

Nama Tauag, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Lester Theodore Vickers Jr. April 6 2007 /Medical 10:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23122 Shady Mile Drive California St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours Director 025-28-1918 11/06/1937 Massachusetts Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Directo Maryland St. Mary's California 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23122 Shady Mile Drive Funeral 20619 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene.
nt: If item 27 Is marked other than "naturar", or items 23s United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u></u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tugboat Captain Merchant Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Theodore Vickers Sr. 2 Sarah Helen Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trauonce. Grace Anne Dohrman/Wife 23122 Shady Mile Drive, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre 04/10/2007 | Charlotte Hall, MD Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Physician heart tailure /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Itypertension physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 9.2 s autopsy performed? Yes 2 No certificate ha rector, page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Residence 6 Other (Specify) 28a, Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060210 4/6/07 nush 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hollywood, MD 20636 Notch Rd Amish 24035 Three

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Carl James Woyick 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number Age (In yrs, last birthday) If Under 24 Hrs. Hours Min, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 XM 2 ☐ F Director 232-32-8960 78 July 11,1928 WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 TyYes 2 □ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 843 Frederick Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinations. 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:1946-1949 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Mantanance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Stanley Woyick ဂ Margaret Novack 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Janet E. Woyick/Wife</u> 843 Frederick Street Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rehobeth U.M.Cemetery 04/16/07 Mercxersburg, PA 21 Signature of Funeral Service Licens 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RTEMOSCENO ANU)(01 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes P.O. 9 I Inknown 9 Unknown Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury within 24 hours aner common To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical waminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medical E 29d. Date signed (Mofth, Day, Year) 29c. License number 29b. Signat 30. Name and address of p 5

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 04 07 Physician 12:35 P.™ WILMA WARE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WMHS BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Feb 15, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 1 🗋 M ЖD 220-16-5780 82 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Y□Yes 2□No Cumberland MD Allegany Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21502 USA 901 Seton Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★□Yes 2□No If Yes, Give Year or Dates: WWII 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, the Medical Examiner me 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Textile Spinning Dept. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H Byrle (MacKenzie) Lease Arlie T. Lease ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cumberland MD 21502 daughter 14311 Old Lake Drive. Linda Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition If it Department of Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 4/18/2007 Lease Cemetery MD Cresaptown 4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral/Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du for as a consequence of): Examiner BSTRUCTURE LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Mo 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. I Director: Af din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

e Funeral within 2. To the I

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 0 Khanna 31. Date filed (Month, Day, Year) APR 1 9

2007

29b. Signature and title of certifier

and manner stated.

2. Registrar's Signature

ast National Highway, LaVale, MD 21562

29c. License number

29d. Date signed (Month, Day, Year)

Funera Directo

To Developer's Name (First, Media, Last) To Developer's Name (First, Media, Last) To Developer's Name (First, Media, Last) To Developer's Name (First, Media, Last) To Developer's Name (First, Media, Last) To Search (Second) To Developer's Name (First, Media, Last) To Developer's Name (First, Media, Marker) To Developer's Name	•	1 _ State			State of	of Mary		•	tment of F ificate of	lealth and	Mental Hy				
TIDA SUE WALKER 4. Facility Name of first described, pive severed and number) PRINCE GEORGE'S HOSPITAL Social Standard, Number 5. Social Standard, Number 5. Social Standard, Number 5. Social Standard, Number 5. Social Standard, Number 5. Social Standard, Number 6. Social Standard, Number 6. Social Standard, Number 6. Social Standard, Number 7. Social Standard, Number 7. Social Standard, Number 7. Social Standard, Number 10. Social	77	Registrar 1. Decedent's Nar	ne (First, Middle	e, Last)				Certi	Ticale of	Death	2. Qate of D		200	17	3. Time of Death
PRINCE CEORGE'S Association Prince Ceorge Association Pr		TDA			CIIF		UATE	סי				D 1	-		7.30 1
Special Source Number 10			(If not institution	n, give st		ımber)	WALKI		4b. City, Town, o	or Location of Dea		4			1 1 30 A
Total Contro		PRINCE	GEORGE	'S H	OSPIT	AL]	PRINC	E GE	ORGE'S
Usual Residence of Deceders 100. Centry 100. City, Town of Location 100. Inside Cay Lin 100. Inside Cay Lin 100. Enter Cay					M 2 ⊠ F			A			. (Month, E	ay, Yea		Cou	ntry)
Top. Street and Number Top. Care Top		3,,,,,,		L	21	/ -		13.			JUNE 1	.7_19	932	VIR	GINIA
1.1. Martial Status 1.2. Was Decodert of Hispanic Origin? (Speedy: Yes or No- glack, Write, and Couparities 1.2. Was Decodert of Hispanic Origin? (Speedy: Speedy:	Ì	10a. State	10b. County			10	c. City, Town	or Loca	ation						10d. Inside City Limit
1.1. Martial Status 1.2. Was Decodert of Hispanic Origin? (Speedy: Yes or No- glack, Write, and Couparities 1.2. Was Decodert of Hispanic Origin? (Speedy: Speedy:	2	MD	PRINC	E GE	ORGE '	S	CAI	PITO	L HEIGH	rs	_				1∭XYes 2☐N
1 1 1 1 1 1 1 1 1 1	2			RHAM	I DRIV	E				3				hat Cou	ntry?
1 See Care	0	11. Marital Status		12			in U.S.	13. Wa	as Decedent of H	Hispanic Origin? (Specify Yes or N	lo-			
Securities Sec				ned	1 ☐ Yes	2 3 No		_			rto Rican, etc.)				
17. Father's Name (First, Modelle, Last) 18. Mother's Name (First, Modelle, MacKEY 19. Making Address (Sireet and Number or Rural Route Number). City or Town, State, Zip Code) 19. Mailing Address (Sireet and Number or Rural Route Number). City or Town, State, Zip Code) 18. Mathematics of the Point Individual Point Ind		3 Widowed	4 Divorced	ı	IT Yes, G	rve		1 _	JYes 2LXNo	Specify:			Specify:	BI.	ACK
17. Farmer's Namer (Piest, Middle), Last 19. Mailing Address (Siroer and Number or Rural Route Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mary Address (Siroer and Number) 19. Mary Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and Number) 19. Mailing Address (Siroer and N	2	(Spi)		(Give kir	nd of work done	during most of w	orkin g	16b.	Kind of Bus	siness/Ir	ndustry
19. Mariner's Name (First, Middle), Last) 19. Mailing Address (Street and Number or Fural Route Number), City or Town, State, Zip Code)	Ē	Elementary/Sec	condary (0-12)		College	(1-4or 5+)						PR	TVATE		
CHARLIE WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Strees and Number or Paral Route Number, City or Town, State, Zip Code) BARBARA A. WALKER/DAUGHTER 8.252 QUITE BOWILE, MARYLAND 20720 20a. Method of Disposition 1 28 Bural 2 Commation 3 Chemoval from State 4 Constant on 5 Cother (Speechy) 21. Signature of Funders Service Uconsey 22. Name and Address of Facility 23. Name and Address of Facility 24. Name of Losses (Final disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Was descedent pregnant in the past 12 morths? 26. EQUAL COLOR OF COMMAN (Speechy) 27. Due to (or as a consequence of): 28. Part Letter the disease or condition 29b. Vas descedent pregnant in the past 12 morths? 29b. Was descedent pregnant in the past 1				(ast)					TILLICE TO S		me (First Middl			a)	
199. Maling Address (Sirear and Number or Rural Route Number, Cety or Town, State, Zip Code) BARBARA A. WALKER/DAUGHTER 20a. Method of Disposition 1 XBurial 2 (Cremation 3 Removal from State 4 Donaton 5 Other (Speech) 2 (CEDAR HILL CEMETER) 2 (AND USER) 2 (Signature of Funeral Service Leense) 2 (Signature of Funer	۵													-,	
20a. Method of Disposition 1	=	19a. Informant's	Name/Relations	ship (Type	e, Print)		19b.	Mailing	Address (Street	and Number or F	Rural Route Num	ber, City	or Town, S	State, Zi	o Code)
Signature of Funeral Service License CEDAR HILL CEMETERY 4/7/2007 SUITLAND, MARYLAND	1	BARBARA	A. WAL	KER/	DAUGE	ITER	82	252	QUILL PO	DINT DRI	VE BOWIE	E, MAI	RYLANI	D 2	0720
23-Brail 24-Directors 23-Directors 23-Direc		20a. Method of Di	isposition			2	Ob. Place of	Disposit	tion (Name of	1		_			own, State
22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 74.74 LANDUVER KOAD LANDUVER, MARYLAND 20. 22a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interest the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.					moval from	State					/2007	SU	ITLAN	D.MA	RYLAND
Approximate Approximate					1	//	ODDIN	_				-			
shock, or heart failure, flust only one cause on each line. MALIGNANT CHANGA APRATTYPHIA Sequentially list conditions are all lines as a consequence off);	ı	* K	D. 17	1-6	al	/									
Part II. Uther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 236. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of cause death 1 Yes 2 No No 24b. Were autopsy findings available prior to completion of cause death 1 Yes 2 No No No No No No No		shock, or he Immediate Cause disease or condit	eart failure, List e (Final ion	r complicationly one	MA	each line.		ot enter	the mode of dyi	ng, such as cardi	ac or respiratory	arrest,			Approximate
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	Examin	shock, or he Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Uni Cause (Disease that initiated ever	e (Final ion conditions, immediate derlying or injury	a. b.	Due to	each line. Cor as a co Cor as a co	NAN onsequence of onsequence of	of enter	the mode of dyi	ng, such as cardi	ac or respiratory	arrest,			Approximate Interval Between
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	Examin	shock, or he Immediate Causr disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unc Cause (Disease that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1	e (Final e) conditions, immediate derlying or injury its) Last ent pregnant 2 months?	a. b. c. d.	Due to	each line. Cor as a co Cor as a co (or as a co utcome of p birth 2 nant at time	onsequence of the consequence of	of enter	the mode of dying the dying the mode of dying the mode of dying the mode of dying th	ng, such as cardi	ac or respiratory	arrest,	2477770 DEN	MIA	Approximate Interval Between Onset and Death
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	Examin	shock, or he Immediate Caust disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death 1	ent failure List e (Final cion) conditions, immediate derlying or injury tis) Last ent pregnant 2 months?	a. b. c. d.	Due to	each line. Cor as a co (or as a co (or as a co utcome of p birth 2 inant at time nown	MAN prisequence of the consequence f enter	the mode of dying the dying the mode of dying the mode of dying the mode of dying th	ng, such as cardi	ac or respiratory	arrest,	2477770 DEN	MIA	Approximate Interval Between Onset and Death	
25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 1 Natural 5 Pending investigation 3 Note determined 27. Accident 3 Suicide 4 Homicide 28. Place of Injury at Work? 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No 28. Injury at Work? 28. Describe how injury occurred 28. Describe how injury occurred 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Certifier (Check only one) 29. Signature and title of certifier 29. Displace of Death (Check only one) 28. Describe how injury occurred 28. Describe how injury occurred 28. Location (Street and Number or Rural Route Number, City or Town, State)	by Physician/Medical Examin	shock, or he Immediate Caust disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death 1	ent failure List e (Final cion) conditions, immediate derlying or injury tis) Last ent pregnant 2 months?	a. b. c. d.	Due to	each line. Cor as a co (or as a co (or as a co utcome of p birth 2 inant at time nown	MAN prisequence of the consequence f enter	the mode of dying the dying the mode of dying the mode of dying the mode of dying th	ng, such as cardi	ac or respiratory A A C 23e. Dic	arrest,	23d. Date Mon	e of delivith	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park	
Check only one) Pospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	ompleted by Physician/Medical Examin	shock, or he Immediate Caust disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease that initiated ever resulting in death Imperior of the past 1 1 Yes 2 9 Unknow	ent failure List e (Final cion) conditions, immediate derlying or injury tis) Last ent pregnant 2 months?	a. b. c. d.	Due to	each line. Cor as a co (or as a co (or as a co utcome of p birth 2 inant at time nown	MAN prisequence of the consequence f enter	the mode of dying the dying the mode of dying the mode of dying the mode of dying th	ng, such as cardi	23e. Dic	arrest, 72.00 Liobacco Yes Is an opsy	23d. Date Mon 23d. V 22€ No	e of delivith ibute to 3 Pro Vere autrior to coeath?	Approximate Interval Between Onset and Death Onset and Death Park The Cause of death? The Cause of death? The Cause of death? The Cause of death? The Cause of death?	
27. Manner of Death 1 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State) 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	e completed by Physician/Medical Examin	shock, or he Immediate Cause disease or condiferesulting in death Sequentially list if any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death Imperior of the cause) (Disease o	e (Final ion) conditions, immediate derlying or injury that the conditions in the	a. b. c. d.	Due to	each line. Cor as a co (or as a co (or as a co utcome of p birth 2 inant at time nown	MAN prisequence of the consequence f enter	the mode of dying the dying the mode of dying the mode of dying the mode of dying th	y ven in Part I.	23e. Dic	I tobacco	23d. Date Mon 23d. V 22€ No	e of delivith ibute to 3 Pro Vere autrior to coeath?	Approximate Interval Between Onset and Death Onset and Death Park The Cause of death? The Cause of death? The Cause of death? The Cause of death? The Cause of death?	
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. Certifier 29c. License number 29d. Date signed (Month, Dey, Year)	o Be Completed by Physician/Medical Examin	shock, or he Immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause, Enter Unicause (Oisease that initiated ever resulting in death Immediate). Was deceded in the past 1 1 Yes 2 9 Unknow Part II. Other sign	ent pregnant 2 months?	a. b. c. d. 23	Due to Due to Due to	each line. CLG (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co	onsequence of insequence of in	of enter (i) (i) (ii) (iii) the mode of dying the mode of dying cause ground the mode of d	y 26. Place of D	23e. Dic 1 24a. We aut per peath (Check only	I tobacco	23d. Date Mon 23d. Date Mon 250 No 24b. W P No 1	e of delivith ibute to the state of the sta	Approximate Interval Between Onset and Death Onset and Death	
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year)	on: 10 be completed by Physician/Medical Examin	shock, or he Immediate Causi disease or condiresulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death 1 Tes 2 Unknow Part II. Other sign Unknow Part II. Other sign 25. Was case refexaminer? 1 Yes 2 27. Manner of De 1 Natural 2 Accident	erred to medica The product of the	a. b. c. d. 23 ons cont.	Due to Due to Due to Due to	each line. Coras a conclusion of position of position of position of position of the conclusion of th	onsequence of the sequence of	of enter final policy of the under	the mode of dying the mode of dying cause grant and the control of	y y y y y y y y y y y y y	23e. Dic 24a. We aput put put put put put put put put put	I tobacco	23d. Date Mon 23d. Date Mon 24b. W 1 6 □Othe jury occurre	e of delivation to control of yes	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park
≥ 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)	on; To Be Completed by Physician/Medical Examin	shock, or he Immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Incause (Disease that initiated ever resulting in death 1 Yes 2 9 Unknow Part II. Other sign 1 Yes 2 25. Was case refexaminer? 1 Yes 2 27. Manner of De 1 Natural 2 Accident 3 Suicide	erred to medica SNo at failure List e (Final ion) conditions, immediate derlying or injury its) Last ent pregnant 2 months? 2 Mo nifficent condition SNo ath 5 Pendir investi 6 Qould	a. b. c. d. 23 ons conti	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. CLG (or as a co (o	onsequence of consequence of consequ	of enter final policy of the under	the mode of dying the mode of dying cause grant and the control of	y y y y y y y y y y y y y	23e. Dic 24a. We aut per 24d. Check only Home 5 Re 28f. Location	I tobacco	23d. Date Mon 24b. W Country	e of delivation to control of yes	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Certification: 10 Be Completed by Physician/Medical Examin	shock, or he Immediate Caust disease or condit resulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease that initiated ever resulting in death 1 Yes 2 Unknow Part II. Other sign Yes 2 Yes 3 Yes 3 Yes 3 Yes 3 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 5 Yes 5 Yes 6	erred to medica No ath Percent to medica No ath Son All Percent to medica No ath Son Pendir Percent to Son All Son Pendir Son Could	a. b. c. d. 23 ons cont. Ho	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Coras a concorate of coras a concorate	onsequence of consequence of consequ	of enter final patient ime of niury death of d	the mode of dying the mode of dying cause growther (specify)	y ven in Part I. 26. Place of D ner: 4 Nursing ry at rk? Yes 2 No	23e. Dic. 24a. We aptroper seath (Check only Home 5 Received 28d. Described 28f. Location City or Tope, and due to the control of the contro	I tobacco Yes Is an opsy formed? (Street a own, State e causele	23d. Date Monor of use contribution of 25 No 24b. Who 1 1 6 Other jury occurred and Number atter (s) and mark	e of delivith a of delivith bute to a of delivith were autorior to coeath? Yes ar (Special	Approximate Interval Between Onset and Death Onset and Death Part of the cause of death? Day Year Day Year Dably 4 Unknow opsy findings availated and Poute Number, stated.
	edical Certification; To Be Completed by Physician/Medical Examin	shock, or he Immediate Causidisease or condiresulting in death Sequentially list of any, leading to cause. Enter Unicause (Disease of that initiated ever resulting in death 1 Yes 2 9 Unknow Part II. Other sign 25. Was case refexaminer? Yes 2 27. Manner of De 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	erred to medica SNo ath Sin Pendir investi 6 Could 2 Medical	a. b. c. d. 23 ons cont. Ho	Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. Coras a concorate of coras a concorate	onsequence of consequence of consequ	of enter final patient ime of niury death of d	ctopic pregnancother (specify)	y ven in Part I. 26. Place of D ner: 4 \(\text{Nursing} \) Ny at ix? Yes 2 \(\text{No} \) me, date and pla opinion, death oc se number	23e. Did 1 24a. We aut per 1 Yes eath (Check only Home 5 Re 28d. Describe 28f. Location City or Toe, and due to thoursed at the time	I tobacco I tobacco I yes Is an opsy oformed? 2 In a company of the company o	23d. Date Mon 23d. Date Mon 24b. Wo 24b. Wo 1 6 Other jury occurre and Number (s) and marand place, a	e of delivith abute to some authorior to constant of the earth? Gr (Special or or Runner as and due some author)	Approximate Interval Between Onset and Death Onset and Death Onset and Death Page 1975

DHMH 17 Rev 1/2001

Registrar

APR 0 5 2007

Physician Model As Facility Name of find institution, give street and number) As Annix ARUNE ARU	12717	Reg. No.	Reg	Death	nent of H cate of L	•	State of Marylar	ma (Cinne Middle Loce)	1 - For State Registrar					
Second Security Number Second Security Number Security Second Security Number Security	3. Time of Death 4:49 P	Day Year 31 2007 4c. County of Death		M Location of Death		4b.	treet and number)	AUDIUS (If not institution, give s	CL.	cal	/Medi	£,		
17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Marden Sumarne) 19, Mailing Address (Sireat and Number of Parial Route Number, City or Town, State, Zip YONNE K. WALKER/WIFE 172.13 RUSSET DRIVE BOWIE, MARYLAND 20.716 19, Maryland of Capacity, Crimatoloy or other place) 20a. Method of Disposition 10 Burial 2 (Externation 3) Removal from State 20b. Place of Disposition (Name of Capacity) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Place of Disposition (Name of Capacity) 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.	lace (State or Foreign try) TH CAROLIN	h y, Year) 9. Birth Cou		If Under 24 Hrs. Hours Min.	Inder 1 Year	/ast birthday) If t	7. Age (In yrs.	Number 6. Sex 2148	5. Social Security N 25040-2	4.7 s	Director	* 1		
17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Marden Sumarne) 19, Mailing Address (Sireat and Number of Parial Route Number, City or Town, State, Zip YONNE K. WALKER/WIFE 172.13 RUSSET DRIVE BOWIE, MARYLAND 20.716 19, Maryland of Capacity, Crimatoloy or other place) 20a. Method of Disposition 10 Burial 2 (Externation 3) Removal from State 20b. Place of Disposition (Name of Capacity) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Place of Disposition (Name of Capacity) 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.	0d. Inside City Limits 1 ☑ Yes 2 ☐ No try?		10g			BOWIE		10b. County PRINCE GE	10a. State	rector	28a-f show	bookland who		
17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Marden Sumarne) 19, Mailing Address (Sireat and Number of Parial Route Number, City or Town, State, Zip YONNE K. WALKER/WIFE 172.13 RUSSET DRIVE BOWIE, MARYLAND 20.716 19, Maryland of Capacity, Crimatoloy or other place) 20a. Method of Disposition 10 Burial 2 (Externation 3) Removal from State 20b. Place of Disposition (Name of Capacity) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Place of Disposition (Name of Capacity) 22. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.74 LANDOVER ROAD LANDOVER, MARYLAND 20. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74. Name and Address of Facility J. B. JENKINS FUNERA 74.	etc. ACK	14. Race - Ameri Black, White, Specify: BL	16	edent of Hispanic Origin? (Specify Yes or No- ecify Cuban, Mexican, Puerto Rican, etc.) 2 No Specify:		rforce	2. Was Decedent Ever in U Armed Forces? 1 XYes 2 No Ai If Yes, Give Year or Dates:	rried 2 🔯 Married 4 Divorced 15. Decedent's Educ	11. Marital Status 1 Never Marr 3 Widowed	by Funeral	atural, or itama 23a ol sal Examinar must be	5-0036		
Section Sect		GOVERNMENT	ing	HEMIST	OT use retired	life. DO N		condary (0-12)	Elementary/Seco	Complet	lygiene. ther than "n nt, the Medi	N S		
200. Method of Disposition Date 200. Location - City or To Cemeratory, cerematory or other place) Date 200. Location - City or To Cemeratory, cerematory or other place) PTVFRDALE CREMATORY 4/7/2007 RTVERDALE ode)	}	MULLER	EDELLE	dress (Street a	19b. Mailing Ad		WALKE	COHEN	To Be	nd Mental h marked of	irylanc			
Physician //Medical Examiner Physician //Medical Examiner Sequentially its conditions, if any, leading to immediate cause (Final disease or conditions, if any, leading to immediate cause. Enter Underlying as consequence of): Due to (or as a	wn, State REMATORY L HOME	YLAND 20716 20c. Location - City or T RIVERDALE C NKINS FUNERA	Date 2007 R. B. JENK	DRIVE BOWN Part A 4 / 7 / 20 S of Facility J.	USSET (Name of or other place) REMATO Re and Address	17213 F Place of Disposition cometery, cremator, VERDALE (emoval from State	sposition Communities 3 Respectively	20a. Method of Dis 1 Burial 2 4 Donation		Baltimore, Ma permit. Pages 1 and 2 si Department of Health an Important: If Itam 27 is r any injury or other traur once.			
Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated exercises as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was also as a consequence of): Divertified to be an arranged of the part it was an autopsy and part of the part	Approximate Interval Between Onset and Death	rest,	or respiratory arrest	g, such as cardiac or		Y HEMMORI	PULMONAR	ert failure. Listonly one o (Final ion	Immediate Cause disease or condition		Medical			
25. Was case referred to medical examiner? 1						uence of): ULITIS uence of):	DIVERTIC	mmediate lerlying or injury ts	Cause (Disease or that initiated events	dical Examiner	/Medical Examiner	V [®] i		
25. Was case referred to medical examiner? 1	ry Day Year					il death 3 □Ecto	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	2 months?	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			The death certifie		
25. Was case referred to medical examiner? 1				on in Part I.	ing cause give	ulting in the underh			1	by	en signed b ould be deta	ords, P		
26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Injury at Work? 3 Suicide 4 Homicide 28. Place of Injury 28. Injury at Work? 4 Homicide 28. Place of Injury 28. Place of Injury 28. Place of Injury 28. Injury at Work? 4 Homicide 28. Place of Injury 28. Place of	osy findings available npletion of cause of 2 1 No	rsy prior to co med? death? 2√√2 No 1 ☐ Yes	autopsy performe 1 ☐ Yes 2 ½						05 Wes see selection		ficete has be n, pege 2 sh	al Keco		
3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 See Place of Injury - At home, farm, street, factory, office 5 See Place of Injury - At home, farm, street, factory, office 5 See Place of Injury - At home, farm, street, factory, office 6 City or Town, State))	lence 6 □Other (Speci	me 5 ☐ Residend	at 28	28c. Injury Work	28b. Time of Injury	1 □ Inpatient 2 ₺	₹ No Ho ath 5 □ Pending	examiner? 1 ☐ Yes 2 ☑ 27. Manner of Deat 1 ☑ Natural	2	ith. r. After this certi e funeral direct	ION OT VIII		
29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st.	Route Number,			28	ctory, office	ome, farm, street, f.	28e. Place of Injury - At h building, etc. (Special	dataminad	3 Suicide	Certifica	rs after des ai Director ed in by the	DIVIS		
Of the state of th	ated. the cause(s)	ause(s) and manner as s date and place, and due t	and due to the caused at the time, date	e, date and place, ar inion, death occurred	irred at the tim ation, in my op	wledge, death occi	er: On the basis of examina	2 Medicai Examin	(Clieck uity one)	edical	within 24 hours To the Funeral completely filled	he Hosp		
D31069 APRIL 3		* '	29d				3		1	Σ	m S m S	Tol		
30. Name and oddr of person who completed cause of death (Item 23a) (Type, Print) GEORGE BONE M.D. 1100 MERCANTILE LAND SUITE 135 LARGO MARYLAND 20774 State Registrar 31. Date filed (Month, Day, Year) APR 0 5 2007 32. Registrar's Signature		AND 20774	O MARYLAN	135 LARGO	SUITE	TILE LAND	1100 MERCAN	BONE M.D.	GEORGE 31. Date filed (Mon	te	Sta			

			1 - For State Registrar	State of Marylar		artment of rtificate o		R	eg. No. UU7	12718			
100	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) MARGUERTTE 4a. Facility Name (If not institution, give s	INEZ	WADDY	4b. City, Town	, or Location of Dea	2. Date of Dear Month 4-3-07	th Day Year	8:40 AM			
小男 失 家	Funeral Director		908 BALSAMTREE 1 5. Social Security Number 6. Sex 1579-40-5964		last birthday) Yrs.		OL HEIGH	ITS s. 8. Date of Birth	PRINCE 9. Bit C -2.4 WAS	GEORGE Inthplace (State or Foreign ountry) SH., DC			
	ith the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD PRINCE 0 10e. Street and Number	GEORGE CA	ty, Town or Lo	HEIGH'	Э		0g. Citizen of What C	10d. Inside City Limits			
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at	ed by Funeral Director	908 BALSAMTREE 1 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes		207 Was Decedent of Yes, specify Co	ol Hispanic Origin? (uban, Mexican, Pue lo <i>Specity:</i>		U. S. A 14. Race - Arm. Black, Whi Specify: BLi	erican Indian, ite, etc. ACK			
land 21215-0036	ild be filed within 72 lental Hygiene. Ked other than "ns ic event, Tus Madis	To Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE 17. Father's Name (First, Middle, Last) WILLIAM KENT	e completed) College (1-4or 5+)	(Give	kind of work dor DO NOT use ret	ne during most of wired) PERATOR	ame (First, Middle, I	VETERNS	ADMINISTRA			
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event page.		19a. Informant's Name/Relationship (Ty). LEO WADDY—HUSB 20a. Method of Disposition 1 X Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	AND emoval from State F1	CAPI Place of Disponentery, crem C. LIN	TOL HE sition (Name of natory or other p	TREE PLANTING OF THE PLANTING	MD 20743 Date 9-07 NCKNEY-S	City or Town, State, 20c. Location - City or BRENTWOOD SPANGLER ASH., DC	r Town, State D, MD F. H.				
3760,	Certificate be executed his property of the purial-transit and the p	Ilcai Examiner	Icai	Icai	Icai	23a. Far1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	erthe mode of d		ac or respiratory arre	est,	Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 [Ectopic pregnar			23d. Date of de Month	livery Day Year			
VISION Of VITAI RECORDS, F Attending Physician: The law requires the clost. After this certificate has been signed ector: After this certificate has been signed by the funeral director, page 2 should be de	Completed by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause	given in Part I.	1 ☐ Ye	24b. Were at	o the cause of death? robably 4 Unknown utopsy lindings available completion of cause of				
	Certification: To Be Cor	25. Was case referred to medical examiner? 1 Yes No Ho 27. Manner of Death 17 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ER/Outpatien 28b. Time of Injury ome, larm, stre	28c. In	Other: 4 Nursing	28d. Describe ho	No 1 Yes Yes						
2	Hospital of the hours af Funeral D	Medical Cel	29a. Certifier (Check only one) 1	ician: To the best of my knower: On the basis of examina and mannes stated.	wiedge, death	occurred at the	time, date and place	e, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)			
P	To the within 2 To the complete	Σ	29b. Signature and mile of certifier 30. Name and address of person who cor	mpl fed cause of death (Item	n 23a) (Type 1	mo	45586		9d. Date signed (Mont	-			
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2007	32. Registrar's Signa	mer		(Con	e Cas	70 m	D 20774			

Physicia	an	1. Decedent's Name (First, Middle, La							1	2. Date of De Month		Day	Year	3. Time of Dea
/Medic			ARINE MUR		ORAN					MAR	29	2007		5:32 P
Examin	er	4a. Facility Name (If not institution, giv NATIONAL NAVA)			מדוני	4b. City,		Location of HESDA	Death				y of Death	
		5. Social Security Number 6. S			. L.K. . last birthday)	If Under		If Under 24	4 Hrs.	R Date of Ri	rth		ONTGO	
Funeral Director			□M 2 X]F	75	Yrs.	Months	Days	Hours	Min. (8. Date of Bi (Month, Di 07/17/	193	Ĭ	Wash	place (State or Fo Intry) nington D
How H		10a. State 10b. County		10c. C	ity, Town or Lo	cation								10d. Inside City Li
ital Hygisne. Id other than "natural", or iteme 23a or 28a-f ehow event. The Magical Examiner must be multilist at	by Funeral Director	Virginia Fairfax		Anr	nandale									1 □ Yes 2
or 22	Dire	10e. Street and Number				10f. Zip					10g.	Citizen of	What Cou	intry?
238	rai	8625 Darien Cour		at Francia I	10 40 1		003		0.40				Stat	
He I	-nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 Yes 2	s?	J.S. 13. Y	Yes, spec	offy Cuba	n, Mexican,	n? (Spec Puerto R	ify Yes or No ican, etc.)	0-	Bla	ick, White	•
P, or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		_	- 	2⊠ No	Specify:				Speci	_{fy:} Whi	te
natura ical	Completed	15. Decedent's Ed	fucation		16a. Deced	lent's Usua	al Occupa	ation Juring most o	adadvia		16b.	Kind of E	Business/li	ndustry
Med	npie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4o	or 5+)	life. I	NOT us	se retired))	ot working	7				
ther the	Co		2+		Secret	tary						ucat		
	Be	17. Father's Name (First, Middle, Last)								First, Middle		en Sumai	me)	
narked c	ဥ	William H. Murphy			401 11 11					Probe				
7 is marke traumatic		19a. Informant's Name/Relationship (-				Route Numb				p Code)
em 2		William Bruce You 20a. Method of Disposition	an/ 3011	20b.	8025 Place of Dispo	שנו של Darı sition <i>(Nan</i>	en U	ourt, A	nnan Da	dale,				own, State
5 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐			Place of Dispo cemetery, cren			e) - OE		2007			-	
ortant: injury	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Ar	lington			s of Facility	ן בש ן כ	2007	AY	riing	ton,	/irginia
a de la constant		70: 1	in Do	V 110.					Home	-5308	Rac	rklic	·k Sn	ringfiel
*		23a. Part 1. Enter the disease, or com	olications that caus	ed the dea			-						, K , J P	Approximate
rsician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	,									Interval Betwee Onset and Deal
ledical		disease or condition resulting in death) a. METASTATIC COLON CANCER Due to (or as a consequence of):								145				
miner				.5 0 001150	quondo oiy.									
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a conse	quence of):									
nd Iransi	Examine	that initiated events	c											
sicien and burial-transit	Ä	resulting in death) Last	Due to (or a	as a conse	quence of):									
> %	lical	•	d											
ettending physicien for use as the burial	Physician/Med	IF FEMALE:	220 16 1000 011000											
for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fet	al death 3□	Ectopic pr							ate of deliventh	ery Day Year
ed by the detached	ysic	1 ☐ Yes 2 📉 No 9 ☐ Unknown	4∐Pregnant 9□ Unknown		deatn 5∟	Other (sp.	өспу)							
		Part II. Other significant conditions c	ontributing to death	but not re	sulting in the ur	iderlying ca	ause give	in in Part I.		23e. Did 1	obacc	o use con	tribute to	the cause of death
sign Id be	d by						-			1 🗆	Yes	2 X No	3 🗆 Pro	bably 4 Unkr
should	ompieted									24a. Was	an	24h	Were aut	opsy findings avai
page 2	ф									auto			death?	ompletion of cause
ug co	ŭ.	25. Was case referred to medical			- 10 - 5 - C - 1			OG Place	4 Dooth	THE RESERVE OF THE PARTY OF	-	40	1 ☐ Yes	2∐ No
is certific director.	0	examiner? 1 ☐ Yes 2 ₩ No	Hospital:	tient 2] ER/Outpatien	3 □ DO	Othe			Check only o		€ □O#	nor (Casa	.6.1
등 등	— "	27. Manner of Death	28a. Date of In	jury	28b. Time of		8c. Injury	at		d. Describe				(19)
r: Aft	ate	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Jay 16ai)	Injury	М	Work 1 □ Y	./ ∕es 2 □ No						
Director: I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - At h etc. (Speci	nome, farm, stre	et, factory	r, affice		28	f. Location (City or To			ber or Rur	al Route Number,
To the Funeral Direc completely filled in by	edical Ce	29a. Certifier 1X Certifying Ph	ysician: To the bes	st of my kn	owledge, death	occurred :	at the tim	e, date and	place, an	d due to the	cause	(s) and m	anner as	stated.
the F	ledi	0.1.67	and manner	stated.	audit and/or my	estigation,	, in my op	nnion, death	occurred	at the time,	date a	nd place,	and due t	to the cause(s)
T00	Σ	29b. Signature and title of certifier				29c	. License	number						Day, Year)
		- Xu Wlan	nmy	2			16746	6 (OR)	-				30,2	
0				dooth /lto	m 23a) (Type, I	Drint)		NATTO	NI AT	NAVAL	MET	TCAT	CEN	TED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death April Day **Physician** 2007 Franklin Gordon Allen, Jr. 4:34 P. M 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13801 York Road Apt.J4 Cockeysville Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Yeer) July 20,1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country)
Baltimore, MD. **Funeral** 1**∆**M 2□ F Days Hours Min Months 90 212-28-2035 Director Yrs. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23e or 28e-f ahow traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore County Cockeysville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 13801 York Road Apt.J4 21030 12. Was Decedent Ever in U.S. Armed Forces? 1≦Yes 2 □ No II Yes, Give Year or Dates: W•W•II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Š 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 73 in and Mental Hygiene. 7 is marked other than "no (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Attorney General Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Gordon Allen, Sr. Evelyn Parlange 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: if itam 27 is a Mrs. Ann(nee Updegraff)Allen 13801 York Road Apt.J4 Cockeysville, Maryland21030 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. Evans Funeral Chapel Forest Hill, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Jeffrey 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 wz 23a. Pet t. Enter the disease of complications that caused the death. shock, or heardfailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Provsician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 Probably 4 □Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Vital 1□ Yes 2ŪNo 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Vesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division To the Hospital or Attending Injury 1 Atural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funaral D 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

maklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep	ertificate of Death	Mental Hygie	0.00	12721
ľ	Physic		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
1	/Medi Examir		Margaret Bagwell 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	April 1	8, 2007 4c. County of Death	6:00 AM M
7	, êta e e e	*	1603 Orlando Road	Parkvil If Under 1 Year If Under 24 Hrs	le	Baltimor	·e
	Funeral		5. Social Security Number 6. Sex 1 M 25 F	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign intry)
Ų.	Director		218-16-7692 82 Yrs. Usual Residence of Decedent		12/08/1	924 MD	
	yland now at		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sh iffed	ctor	MD Baltimore Parkvil	ا م			1 □ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	23a ust b		1603 Orlando Road	21234	Ι ,	JSA	
36	d within 72 hours after death with the Maryland glehe. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:		14. Race - Ameri Black, White Specify: Wh	, etc.
5-0036	tural attural			edent's Usual Occupation	166	o. Kind of Business/li	
212	nin 72 n. "n. Medic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of wo. DO NOT use retired)	rking		
7	d within giene.	E	College (1-40r 5+)	rical	1	Baltimore Public Lib	-
g	othe ent,	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		Tary
yland	Ments Ments arked aric e	10E	Samuel H. Tennant	Anna L	. Denny		
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type. Print)	ing Address (Street and Number or Re	ural Route Number, Ci	ity or Town, State, Zi	p Code)
≥,	and ealth m 27			3 Orlando Road Pa	rkville, N	1D 21234	
saitimore,	ges 1 t of H If iten		20a. Method of Disposition 1 ☐ Burial 2☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cree	osition (Name of ematory or other place)		. Location - City or T	own, State
	tmen tant:		4 □ Donation 5 □ Other (Specify) Chesape	ake Crematory	Apr 20 2007 E	Beltsville,	Maryland
g	Depar Mpor mpor my in		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Cremation and Fune:	Alt		
,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	8717 Green Pasture ter the mode of dying, such as cardiac	Drive Da	1+imama Ma	pproximate Interval Between Onset and Death
00/00	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. A CHALAS (A To Due to (or as a consequence of): C. Due to (or as a consequence of): d	the ESOPHAGUS			
	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
colds, r	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to t	he cause of death?
2	aw re	Completed			24a. Was an	24h Were auto	ppsy findings available
ב	The I	mo			autopsy performed	prior to co	mpletion of cause of
g	an: tifica tor, p	Be C	25. Was case referred to medical	26 Place of Dea	th (Check only one)	No 1 ☐ Yes	211No
>	ysici is cei direc	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	ome 5 Residence	6 DOthor (Specie	6.1
) =	Attending Physician: The law refeath. rector: After this certificate has b by the funeral director, page 2 st	⊥ :ü	27. Manner of Death 1 Matural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury		28d. Describe how in		97
2	endir ath. or: Ath	atio	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u>.</u>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stream building, etc. (Specify)	, i	28f. Location (Street City or Town, St	tate)	
	the Hosp lin 24 hou the Funer apletely fill	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deat 2 ★ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	r, and due to the cause rred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
-	With Con	≥	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
)	/		Server (Note in	D0250	10 A	Pril 19	2007
	15		30. Name and address of person who completed cause of death (Item 23a) (Type,	D00250		- 11	
	-Ct-	to	Serva L. (Volan M.) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	831 Satyr H	THEDE	alt. MO	2/234
	Sta Registra		APP 2 0 2007	arle "			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Louis Bacigalupa April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 2922 Georgia Avenue 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 83 Yrs. . Social Security Number 213–18–6116 Birthplace (State or Foreign Country) **Funeral** Hours 1XM 2□F Director 1923 Maryland 4, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2922 Georgia Avenue United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No 1943-If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony L. Bacigalupa Irene Jordan 19a. Informant's Name/Relationship (Type. Print) Ann Norris - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2922 Georgia Avenue, Baltimore, MD 21227 20b. Place of Disposition (Name of Venetery, crematory of other place) West Arundel Grematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 4-20-2007 Odenton, MD 21. Sig ature of Puneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Road, Arbutus, MD 21227 28a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERIS DISTAST Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE DULMONARY DISTASE 1 ☐ Yes 2 No 3 Probably 4 🗹 Unknown Completed CHRONIE RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No HYPERTENSION, PERMAN ENT FIBRILLATION ATRIBL certificate 1 Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

Certification:

after death

I Director:
d in by the f within 24 hours aft To the Funeral Di completely filled in

Medical

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

29b. Signature and title of certifier

APR 2 0

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE

721 POTEE

2007

32. Registrar's Signature

			1 - For Stata Registrar	State of	Maryland /		artment of F			giene Reg. No.	07	12723	
	Physic	ian	1. Decedent's Name (First, Middle,	Last)	Q a	1.1.1	6		2. Date of Dea		Year	3. Time of Death	
	/Medi	cal	ANDRE		130	WI			April	17 2	007	9:51 a M	
	Exami	ner	4a. Facility Namé (If not institution,					Location of Death		4c. Count			
	Funeral		ROCK GLEN NURS:		AB Age (In yrs. last	birthdav)	BALTIM If Under 1 Year	ORE If Under 24 Hrs.	8. Date of Birt	h N/		lace (State or Foreign	
	Director		218-86-8387	1 ⊠ M 2□F	43	Yrs.	Months Days	Hours Min.	(Month, Day	7, Year) 1964	Cour	(LAND	
	pu »		Usual Residence of Decedent 10a, State 10b, County		40. 0. 7				14111 11	1701			
	sho	ō			10c. City, To	own or Lo	ocation				1	0d. Inside City Limits 1 Yes 2 No	
	the A	Director	MARYLAND N/A 10e. Street and Number			BAL	FIMORE 10f. Zip Code	10g. Citizen of What Country?					
	3a of	٥	1190 W NORTHER	יו איני און איני און	VIII E 2 4			0				itry?	
	death ms 2	Funerai	11. Marital Status	12. Was Deced	PT 524 ent Ever in U.S.	13.	2121 Was Decedent of Hill Yes, specify Cuba		ecify Yes or No-	U.S.A	ce - Americ	an Indian.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or Items 23e or 28e-f show event. Ite Medical Examinat must be notified at	þ	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	ĭŽNo		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	Rican, etc.)	1	ck, White, ^{'y:} BLAC	etc.	
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education	16	Sa. Dece	dent's Usual Occupa	ation	ina	16b. Kind of B			
121	- 74	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retired))	ing				
72	filed within Hygiene. other then ent, Inc.M.		10th grade 17. Father's Name (First, Middle, La	atl .		JANI	CORIAL EN					ERSITY	
and	should be filed withir nd Mental Hygiene. marked other than imatic event, Ita M	Be C		31/				18. Mother's Name		Maiden Suman	ne)		
7	2 should and Men 1s marke sumatic	ြ	JAMES W. BOWIE 19a. Informant's Name/Relationship	(Type, Print)	1:	9b. Mailir	ng Address (Street a		GATES	r City or Town	State Zin	Codel	
	od 2 lith a 27 ls		Joan C. Gunn/Mot				W. NORTH						
Jre,	of Hear		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place		Date Date	20c. Location -			
<u>E</u>	nit. Pages partment of P ortent: If ite injury or of		1 XX Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		110		CEMETERY	· !	8-07	WOODLAW	IN. MA	RYLAND	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Sign sturn of Funeral Service Lic	Blown		11	Name and Addres		MMUNITY		•		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
/	Physician	8 4	Immediate Cause (Final disease or condition		SF	P5	15					Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	2	,	0					
	Examiner	ē	Sequentially list conditions	- Agui	red -	Lmn	rune Deg	ficience	y dy ,	idran	il		
9.	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lippe to (or	as a consequenc	e of):			J 4				
h.	icate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	as a consequence	e of):					-		
68760,	sicia e bur	dicail		d.									
			IS SELLING		-							24	
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death		Ectopic pregnancy Other (specify)			23d. Dat Mo	te of deliver	Y Day Year	
	requires that the been signed by th hould be detache	by PI	Part II. Other significant conditions	contributing to deat	n but not resulting	in the un	iderlying cause give	n in Part I.	23e. Did tob	acco use conti	ribute to the	e cause of death?	
ıd	w require been sig should b								1 □ Ye	s 2 No	3 🗌 Proba	abiy 4 ⊟Unknown	
Records,	The law te has b	Completed							24a. Was a autops perform 1 \(\text{Yes} \) 2	y ned?	Were autoportor to combeath?	sy findings available of cause of	
Division of Vital	cien: ertific ector,	Be	25. Was case referred to medical examiner?					26. Place of Death					
of o	hys this	ဥ	1 Yes 2 No		atient 2 ER/C			4 Anursing Hor	ne 5□Reside	nce 6 Oth	er (Specity)		
CO	ding l	Hon	27. Manner of Death 1. Natural 5 Pending		Day Year) 28b.	Time of Injury	28c. Injury Work	? _	28d. Describe ho	w înjury occurr	ed		
i <u>si</u>	Attended death ctor;	fica	2 Accident investigati 3 Suicide 6 Could not determine	be Ope Diese of	Injury - At home, t	arm stre		es 2 □No	28f. Location (St	reet and Numbi	er or Rumi	Route Number	
Ö	tel or A s after el Direc ed in by	Certification:	4 ☐ Homicide determine	building,	etc. (Specify)	,	,,,		City or Town	, State)	or or ribrar	riodio riambor,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.	edicai	29a. Certifier (Check only one)	hysician: To the be miner: On the basis and manner	st of my knowledg of examination a stated.	ge, death nd/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and ma ate and place, a	nner as sta and due to	ited. the cause(s)	
	To t withi To tl comp	W	29b. Signature and title of certifier	Mar			29c. License	number 21649	25	Pol Date signed	8 1	indicause(s) ay, Year) OO7 MO2(219	
	4		30. Name and address of person who	SAS KK	f death (Item 23a)	(Type, F	Print) Wilk	ens A	ve Ba	ltimo	re,	4021229	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regi	trar's Signature		books		_			,	
		-											

Physician
/Medical
Examiner

Funeral Director

death with the Maryland r 28a-f show notified at rral", or Items 23a or 'natural". other traumatic event, the Medical other 1 . Pages 1 and 2 should be fili Iment of Health and Mental H tant; If Item 27 Is marked oth Department of Heal Important: If Item 2 any injury or other

altimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-tran detached Hospital or Attending 24 hours after death. Director:

Division or Vital Records, P.O. Box 68760.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month BAEZ ARMEN 2247 PM 200.7 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMOLE HARBOR If Under 1 Year | If Under 24 Hrs. S. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 ☐ M 2 X F 55 584-42-8625 Puerto Rico D/13/195/ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Brooklyn Yes 2 No MD BaHimore Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? REGATTA United States America 21225 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Puerto Rican 1 Yes 2 □ No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pastor Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Gabriel Marquez Elevtila Daza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Baez / Son 12000 Falling Creek Drive Manassas 20112 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2007 Norbeck Memorial Garden Onley, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel Maryland 20707 wun men 2 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIO PULMONARY ARREST SECONDARY Due to (or as a consequence of): IVER CIRRHOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine END STAGE RENAL DISEASE Due to (or as a consequence of) Physician/Medical HEPATITIS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death S ☐ Other (specify) □Yes 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🔀 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 3 00A P 2 ☐ ER/Outpatient Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural S Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ignature a 29c. License number 29b. 29d. Date signed (Month, Day, Year) 1042041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4115 Ritchie Huy Brooklyn Park Md. 21225 ALEGADO, 32. Registrar's Signature State Registrar

To the Funeral

			1 - For State Registrar	State of Maryla		artment of F			iene	07	2725
	Physici	an	1. Decedent's Name (First, Middle, La	ist)		2-011	A - 1	2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	al	DANIEL			BERLI		AFRIL	14	2007	3.45 PM
	Examin	er	4a. Facility Name (If not institution, give	1.4	1		or Location of Death Moル上 C		4c. Coun	ity of Death	
	Funeral		THE JOHNS HOPK 5. Social Security Number 6. 9		. last birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birthpla	ce (State or Foreign
	Director		Usual Residence of Decedent	1 M 2 □ F 59	Yrs.	Months Days	Hours Min.	10/2719	Year) 947	Country	NY
	arylan		10a. State 10b. County		ity, Town or Lo					100	d. Inside City Limits
	88a-1	ecto	MD BALTIMO	JKE	PHOENIX						1 ☐ Yes 2 💢 No
	with the	直	10e. Street and Number	1.77		10f. Zip Code		1	_	f What Country	y?
	ns 23	era	14825 HUNTING WA	12. Was Decedent Ever in I	J.S. 13.	21131 Was Decedent of h	Hisnanic Origin? (Si	pecify Yes or No-	U. S.	A. ace - Americar	n Indian.
920	be filed within 72 hours after death with the Maryland Ital Hygiene. od other then "natural", or Items 23e or 28e-f ehow event, the Medical Examiner must be multiled at	by Funeral Director	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2)(1) No	Hispanic Origin? (S) an, Mexican, Puerto Specify:	o Rican, etc.)		ack, White, et	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	pation	kina		Business/Indu	•
2	C	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	VICE	PRESIDEN	during most of world)	U	IS F00[) SERVI	CES
7	filed w Hygier Ather th		17 Eather's Name /First Middle I as	5+	1102	HŮMĀN	RESOURCE		Maidan Cum	1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then any njury or other traumatic event, I is MORG.	To Be	17. Father's Name (First, Middle, Last JACK	BE	RLIANT		SARA	ne (First, Middle, M		S	AVITT
Mar	12 sh h and 7 Is m Iraum		19a. Informant's Name/Relationship	**		_	and Number or Ru			-	ode)
	1 and Healt em 2 ther		CHRISTINE BERLIA 20a. Method of Disposition				G WAY - P			L 31 n - City or Tow	n. State
no	ages int of t: if it		1 ☐ Burial 2 ☐ Cremation 3 [sition (Name of matory or other pla					.,
Baltimore,	ortan		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice				ORP. 04/2 ess of Facility SC				TNC
ä	Dep fmp eny		1 Rocato /	7			TERSTOWN				
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	A	Approximate
Ш	Physician		Immediate Cause (Final disease or condition		MYELO	GENOUS	LEUK	MIA			Dinset and Death
1	/Medical		resulting in death)	Due to (or as a conse		C(2)11301	, DC0 E			· ·	WEEK
V.	Examiner	_	Sequentially list conditions,	b. MYELDDY		TIC ST	NDROME			6	Manthis
7	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse				20.000		15	40.08
V.	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	c. AUTOLOG Due to (or as a conse		SONE MA	HUROW I	ともいって	ANI	12	YEARS
8760,	sicien sicien	calE		NON Ho	OBGKIN LIMPHOMA						YEARS
687	death certificate be executed e attending physicien and od for use as the burial-transit			d.					-		
Box 6	endin use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnance	i.		23d. D	Date of delivery	
	thet the death certific ed by the attending p detached for use as	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)	y 		N	Month D	ay Year
<u>о</u> .	d by 1	Phy	Part II. Dther significant conditions	Contributing to death but not re	culting in the u	ndashtina sausa ay	on in Port I	22a Did tob	22000 HED 00	atributa to the	cause of death?
Division of Vital Records,	Attending Physicien: The law requires thet the rideath act of the this certificate has been signed by the the funeral director, page 2 should be detached.		ACUTE RENA		Salang in the d	Tidenying Cause giv	veri il Faiti.		es 2 X No		oly 4 □Unknown
900	lawre as be	Completed						24a. Was a			y findings available pletion of cause of
Œ.	The ate he	Com						perform	ned?	death?	
/ita	hysician: The law his certificate has t I director, pege 2 s	Be (25. Was case referred to medical examiner?					th (Check only on	θ)		
0	Physi this c al dire	6	1 Yes 2 No		ER/Outpatier	1 30 DOX		ome 5 Reside			
0	ding Philip Ih. After thi	Certification:	1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk? Yes 2 □ No	28d. Describe ho	w injury occi	ntted	
<u> S</u>	or Attendation of Attendation of the order or or or or or or or or or or or or or	fica	3 Suicide 6 Could not b	OB Place of laive. Att	nome, farm, str			28f. Location (St	reet and Nun	nber or Rural F	Route Number,
_	- 0	Sert	4 Homicide	building, etc. (Spec	ity)	,		City or Town	n, State)		
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Undeck only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, d								ed. ne cause(s)
	Nithin Somple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date sign	ned (Month, Da	ay, Year)
	, - 0		I that C	- MEDICAL &	DETUR	D (064931	1	PRIL	14,2	207
	10		30. Name and address of person who								
	U		DAVID COSGEDVE, GO		TREET,	BALTIMORS	MD 21	724			
	Sta Registr	-	31. Date filed (Month APRY 27)	2007 32 Registrar's Sign	ajer A						

	State of Maryland / Department of Health and Menta 1 - State Registrar Certificate of Death	Al Hygiene 2007 12726
Physician	1. Decedent's Name (First, Middle, Last) 2. Da	ate of Death Day Year 11 18 2007 3. Time of Death O2:20 p M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
	GREATER BALTIMORE MEDICAL CENTER TOWSON 5 Social Security Number 6 Sex 7. Age (in vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Da	BALTIMORE ste of Birth 9. Birthplace (State or Foreign
Funeral Director	Months Days House Min /M	te of Birth 9. Birthplace (State or Foreign Country) n. 7, 1915 Maryland
land bw tf	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
e Mary a-f she tified a	Maryland Baltimore County Pheonix	1 □ Yes 2 X □ No
with the Mar a or 28a-f sh be notified	10e. Street and Number 4011 Eland Road 21131	10g. Citizen of What Country? United States
fter death v r items 23a uner must	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	
4RET 1215-0036 within 72 hours after death with the Maryland feme. than "natural"; or items 23a or 28a-f show he Medical Examiner must be notified at ompleted by Funeral Director		Specify: White
5-00 % hou watura dical E	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-00 21215-00 21215-00 ed within 72 hou yegienen "natura regitaen "natura t, the Medical E	Elementary/Secondary (0-12) 8 College (1-4or 5+) N/A Home Maker	Own Home
MARCS AR. ryland 2121 mould be filed within ind Mental Hygienan ind marked other than market cevent, the Me To Be Compl	17. Father's Name (First, Middle, Last) Chariation Monning Clara Bange	t, Middle, Maiden Surname)
Iryla should Ind Men marker marker marker	19a. Informant's Name/Relationship (Type. Print) (Son-In 19b. Mailing Address (Street and Number or Rural Rou	
Manual Seath are no 27 is no 27 is no 27 is no 127 is no	Mr. Charles Daley, SrLaw) 4011 Eland Road, Pheonix	
nore ages 1 in to f H	20a. Method of Disposition 1 \(\begin{align*} \text{Disposition} & 20b. Place of Disposition (Name of cemetery, crematory or other place) \) Oak Lawn Cemetery Apr. 21,	200, Location - City or Town, State Baltimore, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pepartnent of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 5 Dotter (Specify)	Funeral&Cremation Ctr.P.A.
T m age as		
Physician	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Interval Between Onset and Death
/Medical Examiner	resulting in death) Due to (of as a consequence of):	9/2010
- 11 - 10	Sequentially list conditions, if any, feating to financially acques feating to financially acques feating to financially acques feating to financially acques feating to financially acques feating to financially acques feating to financially acques feating to financially acques feating to financially acquestion and the feating featin	(Years)
executed in and inal-transit	it any, leading to humediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	4 days
68760, ficate be executed physician and s the burial-transit		
x 68 ertifical ling phy e as th	#FFEMALE: 23c. If yes, outcome pf pregnancy	
Division or Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
P.O. nat the d by the etacher	9☐Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
rds, quires th	Part II. Other significant continuous continuous to death but not resulting in the discontinuous given in tart.	1 Yes 2 No 3 Probably 4 Unknown
ecol law rec as beer 2 shou		24a. Was an autopsy available prior to completion of cause of
al R		performed? death? Yes 2 No 1 Yes 2 No
or Vita hysician this certifi al director		5 ☐ Residence 6 ☐ Other (Specify)
ing Ph ing Ph After th uneral		Describe how injury occurred
Division (that or Attending F as after death as after death led in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined investigation 2 Accident investigation M 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ocation (Street and Number or Rural Route Number, ity or Town, State)
Divided on the state of the sta		
o the Hosp tithin 24 hou o the Fune ompletely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death oc	the time, date and place, and due to the cause(s)
	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MUI 10,200+
9	Allisan Habai GRMC 6701 Michaeles Street Trus	on, MD 21204
State Registrar	ADD 6 A 2007 &	

			1- For State of Maryland / Department / Department of Maryland / Department /	artment of Health and Me <i>rtificate of Death</i>		6001	12727
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. F 2. Date of Death	No.	3. Time of Death
ı	Physici		Flourd - Davis		Month E	5th 200	
}	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	Examili	ei	Randallstown Center	Randalestown		and à	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birti	nplace (State or Foreign untry)
	Director		216_34-3343 1× 10 69 Yrs.		ov. 28, 19		
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	Manyll	ō	Maryland N/A Baltin	more			Yes 2 No
	death with the Maryland ms 23s or 28s-f ehow (must be notified at	Directo	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	untry?
	3a or		4408 W. Forest Park Avenue	21207	US	7 7	
	death	Funeral		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		14. Race - Ame	
9	or its	/Fu	1 Never Married 2 Married 1 Yes 2√2 No	1 ☐ Yes 2 ☐XNo Specify:	ican, etc.)	Black, White	•
215-0036	in 72 hours after death with the Marylan I "naturel", or items 23a or 28a-f ehow Bedicel Examinar must be notified at	d by	3 Widowed 4 Divorced Year or Dates:				
င်	n 72 "net	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	7 16b.	Kind of Business/	ndustry
212	with the one.	J L	Flementary/Secondary (0-12)	k Driver		vate Ir	ndustry
ַ		Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (en Sumame)	
<u>a</u>	Aental Aental rked c	To B	Floyd Davis	Bessie	Peters		
Maryland	2 should and Men is marke	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural I	Route Number, City	y or Town, State, Z	ip Code)
_	s 1 and 2 f Health item 27 other tra			W. Forest Park			
9	of H		20a. Method of Disposition 20b. Place of Dispo	matory or other place) 4/21/		Location - City or	Town, State
altimore,			4 □Donation 5 □Other (Specify) Lorraine	e Park Cemetery	Woo		Maryland
n n	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licenses 52	2. Name and Address of Facility Chat 240 Reisterstown	man-Har Rd Bal	ris Fun timore,	eral Home Md21215
			23a. Part 1 Inter the disease, or complications that caused the death. Do not ent speck, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or r	respiratory arrest,		Approximate Interval Between
	Physician		fmmediate Cause (Finaf disease or condition 4	earl Failure			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	1 2			
		_	Sequentiafly list conditions, if any leading to immediate b. Coronary Art Due to (or as a consequence of):	tery Disease			
,	red	Examine	cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last C				
79/8 19/8	death certificate be executed e attending physician and id for use as the burial-transi	dical	d				
٥	ntifica ng ph	0	IF FEMALE:				
ŏ	eath certific attending p I for use as I	an/h	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deli Month	very Day Year
	at the des by the a tached fo	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day
Ľ	res that tigned by	/ Ph	Part fl. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
cords,	requires that een signed b nould be deta	d by			1 🗆 Yes	2 □ No 3 □ Pro	babfy 4 Unknown
ဂ္ဂ		lete			24a. Was an	24b. Were au	topsy findings available ompfetion of cause of
T T	sician: The law certificate has b irector, page 2 st	Completed			autopsy performed	death?	
VItal		Be C	25. Was case referred to medical examiner?	26. Place of Death (10 103	20110
o 	hysic his ce I dire	To	1 Yes 2 Ho Hospital: 1 Inpatient 2 ER/Outpatien	Other: 4 Nursing Home	5 ☐ Residence	6 ☐Other (Spec	ify)
Ĕ	ttending Phys death. stor: After this of the funeral dir	on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how in	jury occurred	
S	death death stor: , the f	Icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str.	M 1 Tyes 2 No	f. Location (Street	and Number or Du	rat Courte Misselver
DIVISION	l or At after d Direct in by	Certification;	4 Homicide determined building, etc. (Specify)	eet, factory, office	City or Town, Sta		rai noule Nurnoer,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or inv	n occurred at the time, date and place, any	d due to the cause	(s) and manner as	stated.
	the b	Med	one) and manner stated. 29b. Signature and title of certifier 4	29c. License number			
	Z Z Z S		and the state of t			Date signed (Month	
	٠, ١		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	7	-10-2	007
	X		Jocelin N. El- Sand	9109/ibortu Ro	ad Ran	dallston	1, MD 21/33
	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature	- Turney No.	mer,	- 4147004	.,
t	Registr	ar	APR 2 0 2007	W.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fb 8866 4-20-07 vf. State of Maryland Popularine of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year FCOS APRIL 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Inversing of Marylans Medical Course AUTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Months Days Hours Min. 76 Director 29 216-24-9381 MD Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Catonsville 10e. Street and Number Pleasant Valley 10f. Zip Code 10g. Citizen of What Country? 21228 Plesant y Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X if Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: 3 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Homemaker House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Grafton Ellis Cora A. Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Thomas Deshields Sr.-Husband 1432 Pleasant Valley Dr., Catonsville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadow Ridge 4/27/07 Elridge, Md 21. Signatury of Funeral Service 22. Name and Address of Facility 1300 Lealbrok av 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sit of k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e Cause (Final Physician RDIONYO disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Box 68760, been signed by the aftending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Tes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? Yes 2 No After this certificate funeral director, pag 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Tes 2 No 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation Injury neral Director; A 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Vernon Ewing 16 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center BE1 Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 27,1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** ∩ M 2 □ F Yrs. 172-34-8205 63 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Wantage Sussex New Jersey 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21 Hickory Lane 07461 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Draftsman Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert P. Ewing Kathryn G. Bothell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Hickory Lane Wantage, NJ 07461 Paul Ewing (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd. Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Interio Scherote Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

ortant: If Item 27 Is marked other than "natural", or items In]ury or other traumatic event, the Medical Examiner mo

Pages 1 and 2 should be finent of Health and Mental I

Directo

þ

Completed

Be

ဥ

physician and s the burial-tran as icate has been sig within 24 hours after death To the Funeral Director:

Examiner Physician/Medical Certification: To Be Completed by

^	lone	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown
		24a. Was an autopsy performed? 1
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

29b. Signature and title of certifig

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

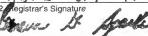
and manner stated.

1614 CHERRAVITE Rd BEL

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 20



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Helen Nora Fischer April 15, 2007 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1811 Barrington Village Ct Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Director 69 20, 1937 218-34-0664 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 Barrington Village Ct 21014 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Hanke Grace Tippins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. Fischer, Jr. 128 Briarcliff Lane Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If Ites any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 04-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UNG Immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown 9 ☐ Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 To the Hospital or Attending Physician: within 24 hours after death. ▼or the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home P 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Manner of eath 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 2 ☐ Accident Injury s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 30. Name and addr-

31. Date filed (Month, Day,

leted

cause of death (Item 23a) (Type, Print)

10755 FALLSRD, SUITE 200 LUTHERVILLES !

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

Physician FRANCES FREY APRIL 2007 3:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 48 OLMSTED GREEN COURT BALTIMORE NONE 8. Date of Birth (Month, Day, Year) 09/01/1940 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. Director 569-50-5461 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 OLMSTED GREEN COURT 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER STATE OF CALIFORNIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 ABRAHAM WASSERMAN BERNICF COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCEL FREY / HUSBAND 48 OLMSTED GREEN COURT, BALTIMORE, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State BALTIMORE HEBREW 04/19/2007 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Feneral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the discass shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 5 mal 00 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform this certificate 2 No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation njury 1 Tes 2 🗌 No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

rleuns Street, Baltimere Maryland 21231

3. Time of Death

2. Date of Death

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

14500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #29d Per Phy G866 4720 poartment of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:15 PM ath

/N Ex

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

OTo the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

sıcı: ledic		Edward R. Gizara Sr.		4	12 2007 9:15 PM				
min		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
		8102 Harris Ave.	Parkville		Baltimore				
ral tor		5. Social Security Number 141-18-8119 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthda) 85 Yrs. Usual Residence of Decedent	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) 4 / 1 3 / 1	year) 921 Senthplace (State or Foreign Country) Pennsylvania				
	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits				
	cto	MD Baltimore Parkv	111e		1 □ Yes रूपूNo				
-	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?				
		8102 Harris Ave.	21234	USA					
	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1☐ Yes ♣ Specify:	14. Race - American Indian, Black, White, etc. Specify: Tub i + 0					
	ed b	3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Sb. Kind of Business/Industry				
1	plet	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	os. Tana of Basinosa massay				
1	Completed	12 shipping clerk Lucas Br							
- 1	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
	2	Louis Gizara	evieve F	Rempalski					
			ling Address (Street and Number or Run	al Route Number, (r, City or Town, State, Zip Code)				
			102 Harris Ave.	Parkvil	lle, MD 21234				
OUCE		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition EVENDER, CI	16.	Oc. Location - City or Town, State Forest Hill, MD					
ouce.			22 Name and Address of Facility Evans Funeral Ch & Cremation Serv	napel 8	3800 Harford Rd. arkville, MD 21234				
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	1 2 V	or respiratory erres	Approximate Interval Between Onset and Death				
n al		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	140 cardin	111/14	CHUM 3 WKS				
er	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
	al Examiner	that initiated events resulting in death) Last C							
	Medica	d							
	ysician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year					
	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?				
		ENASTAGE PENEM UNSER	36	1 ☐ Yes	2 No 3 Probably 4 Unknown				
	Completed	J		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1				
	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)					
	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me Residen	ce 6 □Other (Specify)				
	rinjury occurred								
	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)				
	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as stated. te and place, and due to the cause(s)				
	Σ	29b. Signature and title of certifier	29c. License number 7 3 3	3 290	1. 04 113 1200 fay, Year)				
		30. Name and address of person who completed cause of death (Item 23a) (Type DUNCAN SAMON M.D. 5	Print) LOCH RAVET	V BLVB	BALTIMORE MD				
Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 10		21239.				

State Registrar 31. Date filed (Month, Day, Year)
APR 2 0 2007

DHMH 17 Rev 1/2001

Registrar

P.M.

ORIGINAL

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 11:35 18 2007 4 Gladden, Jr James /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Na 1401 E. Eager Street Baltimore If Under 1 Year If Under 24 Hrs. Date of Birth (Month Day 1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Days Min. Hours Months 1 ▼M 2 □ F 71 216-30-1455 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 XYes 2 No Baltimore MD NA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 USA 1401 E. Eager Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of Baltimore College (1-4or 5+) Elementary/Secondary (0-12) 10th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Nicks James Gladden, ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1401 E. Eager Street Balto, MD 21202 Bernice Lyde-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Cemetery 4-24-07 Balto, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East la ware MD 21202 Balto, 1101 Ε. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months cancer Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2[] No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 687600

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-tranesh

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

determined

6 ☐ Could not be

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MYSICIM

29c. License number D53590

1 [F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) APRIL 19,2007

21205

BRO ADWAY N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 SUD NEY 609 DY MO ROOM BALTIMORE MD

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #4c Per Phy G866 4/20/07 edificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMONTH Year **Physician** GLADDEN DEREK 7 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNIVOF MARYLAND MEDICAL CIP BALDMORE

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday)
3 Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 213-86-3622 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County a or 28a-f show be notified at 28a-f show 1 ZYes 2 No Bultimore Director MD 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 11515 "natural", or items 23a the Medical Examiner must by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) A Driveur 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Fast Foo (ook Ĺ(). Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Vernon Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimone MD permit. Pages 1 and 2 and 2 bepartment of Health ar Important: If Item 27 is any Injury or other trau Gladden 54 Gilda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1/07 Beltmore, MD Funeral Service, P. A. RD Beltmore 1 ☐ Burial 2 D Cremation 3 ☐ Removal from State 21/07 Bay view Cremalon 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility USE 21. Signature of Funeral Service Licensee Belain 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CRYPTOCOCCAL MENINGINS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finme list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1☐ Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ဥ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death
1 X Natural
2 ☐ Accident Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 TYes 2 TNo 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

SANDRA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYSICIAN

N4176435 Q17454

			Please T	ype or Print in B				-	_	ible.		
			1 = For State Registrar	State of Maryland		rtment of F tificate of					1 0 2 0	-
7		3	Registrar Decedent's Name (First, Middle, Last)		061	incate or	Dealli	2. Date of De		11-1-	3. Time of Death	5
	Physici /Medio		FANNY			GOLDS	MITH	APRIL		2007	3:45 A-M	1 .
)	Examin	er	4a. Facility Name (If not institution, give s	, ,	E		LTI MOR		4c. Count	y of Death		
	Funeral Director		5. Social Security Number 6. Sex 217–18–9282	7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 10/02/	v. Year)	Coun	ace (State or Foreign try) ERMANY	ın
700	t w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation					Od. Inside City Limits	s
Mary	a-f she	ctor	MD BALTIM	IORE B	ALTIMO	RE					1 □Yes 2 🛣 No	5
vith th	a or 28 be no	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
heath	ms 23	eral	725 MT. WILSON LA	12. Was Decedent Ever in U.S		21208 Vas Decedent of H		pecify Yes or No	USA - 14. Ra	ce - America	an Indian,	
5-0036 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cub ☐ Yes 2 🛣 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	1	ick, White, 6 fy: WHIT		
		leted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give I	lent's Usual Occup kind of work done	during most of work	king	16b. Kind of E	Business/Ind	ustry	
d 27275 b	giene. er than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		EWIFE	a)		OV	N HOM	E	
and Be file	event,	Be	17. Father's Name (First, Middle, Last) ISADORE	MAIER			18. Mother's Nam	•	Maiden Surna	,	WOLF	
Maryland	th and Mei 7 is marke traumatic	으	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Ru		er, City or Town			-
	ealth a n 27 is ier trau		LARRY GOLDSMITH /		11262	GOODHUE	STREET N				55449	
Baltimore,	nt of Healt : If Item 2 : or other		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	emoval from State	HFVRA	sition (Name of natory or other place AHAVAS	ce)	Date	20c. Location			
	Department Important: any Injury conce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		_CHESE	D . Name and Addre	104/13	9/2007 DL LEVIN			WN, MD	
n s	an gun		Scott M.	rettle	8	900 REIS	TERSTOWN					
		8 18	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final						rrest,		Approximate Interval Between Onset and Death	
	nysician Medical	-	disease or condition resulting in death)	LANGE S Due to (or as a consequence)		RAL H	EMATON	1A		1 -01 14	<i>M</i>	_
E	xaminer		Sequentially list conditions, b						15	sny l	1 day	
V bet	I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ende of):			H	ICAL EXAMÍNEN			
oc, vo	ilan and urlal-transit	= $ $	resulting in death) Last	Due to (or as a conseque	ence of):		111	PPROVED BY ME			<u> </u>	
5875U , ificate be ex	physic s the b	dica	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lue to (or as a consequence of): c. Due to (or as a consequence of): d. IF FEMALE:								_	
.O. BOX 68/60	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Da	ate of deliver	y Day Year	
Hecords, P.O.	n signed b	۾	Part II. Other significant conditions con	tributing to death but not result		derlying cause giv	еп in Part I.				e cause of death?	n
The law re	as bee	Completed						24a. Was autop		Were autop	sy findings available	e
VITAL FI	ficate P		OF Man anno vatored to madical					perfo	rmed? 2 X No	death? 1 ☐ Yes		
r VIII	is cert	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No H	ospital: 1 ∭Sinpatient 2 ☐ E	R/Outpatient	3 DOA Oth	er: 4 ☐ Nursing Ho			her (Snecify	1	-
ing Phy	After th uneral	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor	y at k?	28d. Describe h	now injury occu	rred	<u> </u>	
VISION OF VITA Attending Physician:	death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	APRIL 16, 2007 28e. Place of injury - At hon	8:00 h		Yes 2 XNo	Subject 28f. Location (S	Street and Num		Route Number	-
tal or At	rs after al Dire	Certi	4 Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	3106 on Si	MAKINAT teps of b	rothers ha	City or Tow	n, State) 0 mC			
To the Hospital or	n 24 hou le Funer	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tir estigation, in my o	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and m date and place	anner as sta and due to	ated. the cause(s)	
2	To th comp	M	29b. Signature and title of certifier			29c. License	e number	:	29d. Date signe		- /	\exists
			Mu.	かし		A81	834		MPRI	18	, 2007	
<	34		30. Name and address of person who con $ {\cal R} {\cal M} {\cal M} {\cal M} {\cal A} {\cal N} , $		23а) (Туре, Р	rint)						
B	Sta Registra		31. Date filed (Month, Day, Year) APR 2 0 200	32 degistrar's Signatu	re Ap	we						

		State of Maryland / De 1 - State Amend #1, perMD, g866, 4/21/07 TT	epartment of F Certificate of	Health a	and Mer	ntal Hy	giene Reg. No	200	7 12737
Physicia /Medica	_	1. Decedent's Name (First, Middle, Last) John R. Hale, Jr.			2.	Date of De Month			3. Time of Death
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o		f Death			. County of De	
Funeral		Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe		If Under 2		Date of Bir	rth	Baltimo 9.B	rthplace (State or Foreign
Director		232-34-0329 ^{1X M 2□ F} 77 Yr	s. Months Days	Hours	Min. Au	(Month, De			t Viginia
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location						10d. Inside City Limits
e Mary ka-f sh tiffed	cto	Maryland Harford Belcamp							1 □Yes XX No
with the	Director	10e. Street and Number 1201 Friars Wood Unit 204	10f. Zip Code					izen of What C	Country?
ms 23	Funeral		21017 13. Was Decedent of H If Yes, specify Cub	Hispanic Orig	gin? (Specify		U.S.	14. Race - Am	
urs a	ا ۾	Armed Forces? 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Yes, Give Year or Dates:	If Yes, specify Cub		i, Puerto Ric	an, etc.)		Specify: B1	· .
"natur	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occup Give kind of work done	during most	t of working		16b. K	ind of Busines	s/Industry
within iene. than	дшо	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retire st Furnace	•			Beth	11ehem	Stee1
e filed al Hyg I other vent, 1	BeC	17. Father's Name (First, Middle, Last)			r's Name <i>(F.</i>				
iould b	2	John R. Hale, Sr.			Jenk			·	
and 2 sh ealth and n 27 is n			lailing Address <i>(Street</i> 1 Friars W						
es 1 a of Heg		20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other pla	ice)	Date	,	20c. Lo	ocation - City o	r Town, State
tt. Pages rtment of I rtant: If ite		4□Donation 5□Other (Specify) Garriso	n Forest VA		4-20-2		Owi	ngs Mil	ls, Maryland
permit. Departitimport		21. Signature of Funeral Society Scensee	Inc. 610 W	• MacF	^y Schim Phail	unek Rd Be	Fune 1 Ai	ral Hom	ne of Bel Air 21014
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		ng, such as	cardiac or re	espiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)	epsis						-
Examiner	П								
pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Cheeves of rijury that initiated events							
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of)							
ate be executed hysician and the burial-transit	dical	d							
ertifica ling ph e as th	Med	IF FEMALE:							
The law requires that the death certific are has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey .				23d. Date of d Month	elivery Day Year
res that isigned by be detained	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	ven in Part I.		23e. Did 1	tobacco	use contribute	to the cause of death?
w require been sig should b	ted b	endstoge rend	Jeilu.	~		1 🗆	Yes 2	□ No 3□I	Probably 4 Unknown
The law rate has be page 2 sh	Completed	distets type				24a. Was	psy	24b. Were a	autopsy findings available completion of cause of
		25. Was case referred to medical		Of Diago	of Dooth (C	1□ Yes	ormed?	1 □Ye	
lysicia lis cert directe	To Be	examiner? 1 Yes 2 No	atient 3 DOA Oth		of Death (C rsing Home			6 □Other (Sp	ecify)
ing Ph	uo O	27. Manner of leath 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inju	ry Wo	ry at rk?	28d			ry occurred	
Attend death. ctor: / y the f	licati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm]Yes 2□N		Location /	Street ar	nd Number or I	Rural Route Number.
s after al Dire	Certification:	4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)				City or To			
he Hosp in 24 hou he Fune pletely fil	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, companies on the basis of examination and/companies and manner stated.	leath occurred at the ti or investigation, in my	ime, date an opinion, dea	d place, and th occurred	due to the at the time,	cause(s , date an) and manner d place, and d	as stated. ue to the cause(s)
To t with Com	M	29b. Signature and title of certifier The Control of Certifier MD	29c. Licens	se number	04		29d. Da	te signed (Moi	oth, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	white	16	nter	-,12	ande 1	1, Low M
Stat		31. Date filed (Nonth, Day, Year) 32. Registrar's Signature	9 -00 -				-		
Registra		APR 1 7 2007 May & B	onies						

		. For		and / Depa	artmen	Ink. Ensure At of Health and I			12738	
	•	1 - State Registrar		Ce	rtificate	e of Death		eg. No U U /	16100	
/ Physici /Medi		1. Decedent's Name (First, Middle, Last) Agnes Dorothy I	Hilditch				2. Date of Dea Month APRIL	Day Year 15 2.00	7 9.40 AM	
Examir		4a. Facility Name (If not institution, give str	eet and number)		4b. City,	Town, or Location of Death Baltimore	4c. County of Dea			
		Manor Care Rossvill	Le			imore				
Funeral Director		220-07-9439	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	B. Date of Birth (Month, Day Dec. 19	, 1921 9. Bit	nthplace (State or Foreign ountry) Maryland	
D		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or L	ocation				10d. Inside City Limits	
aryla ehov	Ļ		1.00.	. o.,, . o o. E		timore			1 ☑ Yes 2 ☐ No	
Ba-1	5	Maryland N/A						10g. Citizen of What C	Payenta/2	
or 2	Funeral Director	10e. Street and Number			10f. Zip					
23a	- a	5609 Gardenville A				21206	U. S.			
ems Fr	2	11. Marital Status	2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert	Black, Wh			
rs afte I', or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No ff Yes, Give Year or Dates:		1 🗆 Yeş	2KI No Specify:		Specify:	White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show yilling or other treumatic event, the Medical Examiner must be notified at ADE.	Completed	15. Decedent's Educa (Specify only highest grade of	ation completed)	(Give	kind of wo	al Occupation rk done during most of wo	rking	16b. Kind of Busines	s/Industry	
thin	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	· ·		Own Ho	nm A	
er th	Son	8th			Home	maker	75° 1 10° 1 11°			
al Hy	Be	17. Father's Name (First, Middle, Last)						<i>Maiden Sumame)</i> Lette Hylar	nd	
Want	10	Joseph John Bernw	inkler							
ods :	1	19a. Informant's Name/Refationship (Type	a, Print)			(Street and Number or Re				
alth a		Joseph Hilditch (S	on)	1526	5 Spa	rkland Sprin				
S T S T S T S T S T S T S T S T S T S T		20a. Method of Disposition	1	b. Place of Disp cemetery, cre	osition (Na matory or c	ne of other place)	Date	20c. Location - City of	or Town, State	
Page ento nt: M		1 N Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	len Hav	en Me	m. Park 04/2	0/2007	Glen Burn	ie, Maryland	
artmoorts		21. Signature of Eugeral Service Licensee				nd Address of Facility So				
Depa Impo any Ir		1 /- ent		3	705 E	elair Road,	Baltimon	re, Maryalı	nd 21236	
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	tions that caused the	death. Do not er	nter the mo	de of dying, such as cardia	c or respiratory ai	rest,	Approximate fntervaf Between	
Physician /Medical Examiner		mmediate Cause (Final disease or condition resulting in death)	Due to (or as a con	ESTIV	E 1	HEART ,	FAILU	RE.	Onset and Death	
e executed cian and curial-transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor							
icate be physicia s the bur		d.								
ath certif	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ ₹0	ic. If yes, outcome of pro 1 Live birth 2 4 4 Pregnant at time	Fetal death 3	□Ectopic p			23d. Date of c	delivery Day Year	
that the de led by the a	hys	9 Unknown	9□ Unknown		_		1			
luires than signed	۵	Part If. Other significant conditions cont	inbuting to death but no	t resulting in the	underlying	cause given in Part I.			to the cause of death? Probably 4 Minknown	
e law requ has been je 2 should	Completed						24a. Was	an 24b. Were prior t	autopsy findings available o completion of cause of	
hysicien: The la his certificate had I director, page 2	NO.						1 ☐ Yes	ormed? death 2 No 1 Y	es 21 No	
sien: artific ctor,	Be (25. Was case referred to medical examiner?				1	eath (Check only	one)		
ysic lis ce	ဂ္	1 Yes 2 Ho		2 ER/Outpati				dence 6 Other (S	pecify)	
ding Ph h. After th funeral	tion;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	2Ba. Date of Injury (Month, Day Yea	ar) 2Bb. Time Injury	of M	2Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how infury occurred		
lospital or Attendi 4 hours after death. Funeral Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	2Be. Place of fnjury - building, etc. (S	At home, farm, s	street, facto	ry, office	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,	
A IT 0	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my ler: On the basis of exa and manner stated.	y knowledge, de imination and/or	ath occurre investigation	d at the time, date and place n, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)	
W. To the complete	Me	29b. Signature and title of certifier	1 ,		2	c. License number		29d. Date signed (Mo		
₩ 5 8 4 8 W			weaking)		D 00617	89	APRIL. 16, 2007		
A	1									
10			mpfeted cause of death -AWUAH, 9	(Item 23a) (Typ	e, Print)	LPHIA RD, ST	E 208,	BALTIMORE	, ND 21237	

Baltimore, Maryland 21215-0036

Division or Vital Records. P.O. Box 68760.

			For State	State o	f Marylan		rtment of F		and M	ental Hyg	iene			
			Registrar			Cer	tificate of	Death			Reg. No.			
	Physicia	an	1. Decedent's Name (First, Middle,							2. Date of Deat Month	Day	Year	3. Time of Death	
E	/Medic		Harry John 4a. Facility Name (If not institution,	Heckman			4b. City, Town, o	r Location o		April	18, 2	2007	10:10P M	
	Examin	er	Gilchrist Cen		inder)			Towson			1	11tim	ore	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	if Under 1 Year	If Under		8. Date of Birth		9. Birth	place (State or Foreign	
	Director		725-10-0796	1 ∑ M 2□F	86	Yrs.	Months Days	Hours	Min.	(Month, Day, July 11,	1920	Peni	nsylvania	
7	2		Usual Residence of Decedent		100 Cit	y. Town or Lo	antion						10d Incide Other Limite	
200	shov	<u>_</u>	10a. State 10b. County		100. 01								10d. Inside City Limits 1X Yes 2 □ No	
A d	28a-f	Director	Maryland N/ 10e. Street and Number	A		-	Baltimore 10f. Zip Code	}		11	Og. Citizen of \	Mhat Cou		
him	a or		4609 Kavon Aven	11.0				1206		1 "		S.		
ties E.E. C. C.C.	rai", or items 23a or 28a-f show	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \			gin? (Spe	cify Yes or No-		14. Race - American Indian,		
to the	or iter	Ē	1 ☐ Never Married 2 ☐ Marrie	d 112 Yes	2 No 193	19_							etc.	
	ral", c	l by	3 X Widowed 4 ☐ Divorced	if Y es, Gi Year or D	oates: 194	5	I∐Yes 2∭X No	Specify:			Specify	<i>y</i> : <i>V</i>	√hite	
2 6	natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busin (Specify only highest grade completed) (Give kind of work done during most of working								usiness/Ir	ndustry		
i di	han han	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d) -			Railı			
1 6	Hygie nt, th		17. Father's Name (First, Middle, L	ast)		1	Brakeman	18. Mothe	r's Name	(First, Middle, M				
9 4	ed o	Be c	Earl Heckman							Fenste		•		
t cha	and Mental Hygiene. is marked other than "natur aumatic event, the Medical	ြ	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	g Address (Street						p Code)	
0 00	alth a 27 is r trau		Jeffry G. Heckm	nan (Son)			Kavon Av							
5 -	iten othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	ce)	D	ate	20c. Location -	City or T	own, State	
Page	iny or		1 ☐ Burial 2 XX Cremation : 4 ☐ Donation 5 ☐ Other (<i>Sp</i>		State		Crematory	1	4/21,	/2007 1	Baltimo	re,	Maryland	
i iii	Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic events.		21. Signature of Funeral Service L	icensee	_/		Name and Addre							
			23a. Part1. Enter the disease, or o	complications that	caused the deat							, Land	Approximate	
D	hysician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on	each line.	0	2000		nc				Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	Cecc	CM	NC	er.			mmr	
E	xaminer				(,								
Ę) a2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	uence of):								
Citter	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с			·							
be executed	physician and the burial-transit	Ĕ	resulting in death) Last	Due to	(or as a conseq	uence of):								
5 6	physic the b	dical	133	d										
	attending p	/Me	IF FEMALE:	23c If yes ou	itcome pf pregn	ancv					004 5		-	
d tag	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta	aideath 3□	Ectopic pregnanc Other (specify) _	;y				ate of deliv	very Day Year	
) 2	by the stached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr										
- that	igned b	by Pf	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the u	ndertying cause giv	ven in Part i		23e. Did tob	acco use con	tribute to	the cause of death?	
	should be						····			1 □ Ye	es 2 No	3□ Pro	bably 4 Unknown	
	s bee	Completed								24a. Was a	n 24b.	Were aut	opsy findings available	
The	ate has	mo								autops perforr 1□ Yes	ned2	death?	ompletion of cause of 2 ☐ No	
2 :	rtifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on		103	20110	
hveir	his ce I direc	ToE	1 Yes 2 No	Hospital: 1	Inpatient 2] ER/Outpatier	nt 3□ DOA Oth	ner: 4□ Nu	ursing Hor	me 5 Reside	ence 6 dott	ner (Spec	intozo, co	
	of the rest		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	Wo			28d. Describe ho	w injury occur	rred	U	
) puet	tor: /	cati	2 Accident investigation 3 Suicide 6 Could no	ation				Yes 2 🗆						
To the Description Attending Division. The law requires that the death certific	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 ☐ Homicide determin	1 20e. Plac	e of injury - At n ling, etc. <i>(Sp</i> ec <i>i</i>	ome, tarm, str fy)	eet, factory, office		2	281. Location (St City or Town	reet and Numl n, State)	ber or Rui	ral Route Number,	
- 4	nerai		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	owledge, deat	h occurred at the t	ime, date ar	nd place, a	and due to the c	ause(s) and m	anner as	stated.	
H of	lin 24 I	Medical	(Check only 2 Medical E	xaminer: On the l and mar	basis of examination	ation and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time, d	ate and place,	and due	to the cause(s)	
F	2 ₹ 2 5	2	29b. Signature and title of certifier	*	10		29c. Licens	se number	,	2	9d. Date signe	ed (Month	, Day, Year)	
	1		11/100	Ing 1	aly	us	100	300	J	-	inelle.		1, 2007	
F)		29b. Signature and title of certifier 30. Name and address of person v 31. Date filed (Month, Day, Year) APR 2 0	vho completed cau	ise of death (Iter	m 23a) (Туре, 670	Print) N. Cl	init	les .	St. R	alto.	M	1 21204	
į	Sta Registr		31. Date filed (Month, Day, Year) APR 2. 0	2007 32.	Registrar's Sign	ature A	sele							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Year **Physician** APR 4:02 P M 14 DONALD C. HINTZE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 396-22-9986 7. Age (In yrs. last birthday) 8. Date of Birth 07/9-24-/1 9-29 Birthplace (State or Foreign WICountry) **Funeral** Days Hours Months 1X M 2 F Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f ehow The Medical Examiner must be notified at MD Montgomery Potomac 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854-6 Buckspark Ct. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a eny injury or other traumatic event, Ite Madical Examinat must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status **1**X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Government Industry Coast Guard Officer Elementary/Secondary (0-12) College (1-40g5+) 17. Father's Name (First, Middle, Last)
Eric Hintze 18. Mother's Name (First, Middle, Maiden Sumame) Rosalie Bussie 19b. Mailing Address (Street and Number of Rural Route Number City of Town, State, Zip Code)

6 Buckspark Ct. Potomac, MD 20854-Norma P Hintze/Wife (Type, Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Beltsville, Maryland Apr 18 20a. Method of Disposition Chesapeake Crematory Inc.2007 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapple Eurerald EacCremation Services mo1358 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ISCHEMIC HEART DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifies To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1X Certifying Physician: To the bast of my knowledge death occurred at the time, date and place, and due to the date a(e) and manner accetated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23s Cartiffor 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 16 APR 2007 KuW. Vance 16746 (OR) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 LEE W. VANCE LCDR MC USN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** OBERT HARRISON PM 1927 APRIL 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITHL CITY BALTIMORE Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**/2 x** 1 2 □ F Months Days Hours Min 219-58-5516 Director 55 2-27-1952 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show ns 23a or 28a-f shov must be notified at 1X Yes 2 □ No Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 2525 BARNESLEY PLACE Funeral 21244 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BRICKLAYER CONSTRUCTION 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ ROY H. HARRISON ETHEL SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29172 permit. Pages 1 and 2:
Department of Health as Important: If item 27 is any Injury or other trau CLARA BELL/SISTER 102 ARGUS CIRCLE W. COLUMBIA, SOUTH CAROLINA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 MRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) SMITH FAMILY CEMETERY 4/21/07 FREEMAN, VIRGINIA 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. yre of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Pa 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shifts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS 3 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 14 DAYS PERFORATED DUODENAL WICER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trag Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 APRIL 16,2007 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olino North Street Baltimore, MD 21287-9106 Wolfe MD 600 31. Date filed (Month, Day, Year) 32. gistrar's Signature State APR 2 0 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			state Amend 19b, perI	State of Ma nf, G867, 5/1		artment of H rtificate of I		Mental Hygie	F1 -	3	10710			
	75		Registrar Decedent's Name (First, Middle, Las		,	Tuncate of I	Jean	Reg. 2. Date of Death	No.		3. Time of Death			
	Physici		ROLAND	,		14	STYO		T, 20	Year	M F1:40			
A.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death					
1	Exami	ं	THE JOHNS HOPE	INS HOSPI	TAL	BALTIM	URE CI	74						
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday, 47 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11 26	ar) 59	Coun	lace (State or Foreign try) Cbados			
	p ,		Usual Residence of Decedent		10c. City, Town or L	ocation				1	0d. Inside City Limits			
	arylar show	<u>-</u>	10a. State 10b. County							'	ty∑Yes 2 No			
	the M	Director	MD NA 10e. Street and Number		Balti	10f. Zip Code		100	Citizen of W	Vhat Coun				
	with t be r			Dood			1214	100			,			
	Jeath Trs 23	Funeral	5617 Plymouth 11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race	A .e Americ				
36	perruit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes X☐ No	Specify:	o Hican, etc.)	Black, White, etc. Specify: Black					
21215-0036	2 hou	ted	15. Decedent's Ed			edent's Usual Occup		. Kind of Bu	siness/Inc	dustry				
215	hin 7 e. an "n Medi	Completed	(Specify only highest gra	College (1-4or 5+	life.	e kind of work done DO NOT use retired	during most of world)							
	d withi	50	12th grade	na		Welder					Company			
nd	be filed tal Hygi d other evant, ti	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Mai	ten Surname)					
yla	should be and Mental s marked o umatic eva	-	Richfield Hoyte)			Lavine	Worrell						
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (19b. Mail	ing Address (Street	and Number or Ru	ral Route Number, C	ity or Town,	State, Zip	Code)			
	Health Health tem 27		Mylene Hoyte-Wi 20a, Method of Disposition	.fe	20b. Place of Disp		r Court	Parkvi	LIE,					
altimore,	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory or other plac	i i			_	_			
뜵	it. Partmen		4 Donation 5 Other (Specification of Specification of Sp			morial 22. Name and Addre		21/0/ R	andaı	Ist	own, Md			
Ba	permit. Page Department of important: If any injury or once.		Jola //	Narch	M 4	arch F/	H West ash Ave	, Baltim	ore,	Md	21215			
М			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. METASTATIC TOMILLAR SOLAMOUS CELL CARCINOMA 3 UCON											
Vi	Physician		Immediate Cause (Final disease or condition resulting in death)			TILLAR E	SCHAMOUS	S CELL CAN	KINON	1A /	3 years			
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						J			
ř.		-	Sequentially list conditions,	b. Dus to for as a	eonsaquenes ury:					-				
J	rted nsit	E E	it any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	2 40 10 (0. 40 0	,									
٧,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):									
8760,	e be rsicia e bur	dical		_d										
မ		ധ												
Вох	h cer endin	N/L	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		☐Ectopic pregnanc	v			te of delive	*			
	deat e att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t		Other (specify)			Мо	nth	Day Year			
P.O.	that the death certifi ed by the attending I detached for use as	Physician/M	9 Unknown		A	and the second s	and a Post	00: 0:		ada				
	es De	þ	Part II. Other significant conditions of	-	t not resulting in the	unaenying cause giv	en in Part I.	23e. Did tobac	co use conti		ne cause of death? Dably 4 □Unknown			
oro	w requir been si should	ted						I Tes	2 110	3 FIOL	Jably 4 DOINTOWN			
ec	ne law has b	Completed	MALHUTRITION					24a. Was an autopsy		prior to co	psy findings available mpletion of cause of			
트		ပ္ပ	AIGUMUZGA					performe 1 Yes 2	No	death? 1 ☐ Yes	2 X No			
Vital Records,	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	Hospital:		ont 20 DOA Oth	er.	th (Check only one)						
0	Phys this	J.	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		IN SU DOA	4 □ Nursing H	lome 5 Residence 28d. Describe how		. ,	(y)			
no	fing After fune	Certification:	1 Natural 5 Pending	(Month, Day	Year) Injury	Wo	rk?`` Yes 2 □ No	200. Describe now	injury occurr	180				
Si	Attending r dea h. ector: After by the fune	Cat	3 Suicide 6 Could not be		ry - At home, farm, s			28f. Location (Stree	et and Numb	er or Rura	al Route Number.			
Division	affer Dire	erti	4 ☐ Homicide determined	building, etc	."(Specify)			City or Tòwn, S	State)					
	To the Hospital or Attens within 24 hours after death To the Funeral Director; completely filled by the			nysician: To the best o										
	n 24 h	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta		investigation, in my	opinion, death occu	urred at the time, date	and place,	and due t	o the cause(s)			
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens		1	Date signe					
			4 Dulm 1	moter		RES	000-	AF	PLIL 1	17,2	500			
	N	3	30. Name and address of person who	complete causi of de	eath (Item 23a) (Type	e, Print)	, 0	- danie		1				
	8		PKSEFAH MIN	C4 600	North	oolte Str	ect bal	AF Homore, M	arylo	ind	21287			
	Sta		31. Date filed (Month, Pay Year) APR 2 0	2007 32. Registra	r's Signature	drails?		,	('					
	Regist	rar	1111120	- Total	100 July									

			For State Registrar	State of	Marylar		artmen rtificat		ealth and Death		Reg. N	200	The second	12743
	Physicia	an	Decedent's Name (First, Middle, Last)						2. Dat	te of Death	1 7 -	ear	3. Time of Death
	/Medic	al	Kathryn M. Hall 4a. Facility Name (If not institution, give	street and sum	har)		4h City	Town or	Location of Dea	A/	1116 1	7 200 c. County of I	-	4-15A M
	Examin	er	Loch Raven Center	Street and num	001)		Parkv		LOCATION OF DOC			altimore		
	Funeral		Social Security Number 6. Se		'. Age (In yrs.	last birthday)	If Under Months		If Under 24 Hr Hours Mir	's. 8. Dat	te of Birth onth, Day, Year	9.	. Birthpla	ace (State or Foreign
	Director		214-01-2052]M 2 X]F	95	Yrs.	MOUTUS	Days	TIOUIS	2/2	3/1912	<u> </u>	vary 1	and
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limits
	Maryl f sho	ō	MD Baltimore		Parl	kville								1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number		7 541		10f. Zip	Code			10g. C	itizen of Wha	at Count	ry?
	th with	aiD	7822 Westmoreland Ave.				212	34			U.S	. A		
	r dea	Funerai	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Deced	dent of His	spanic Origin?	(Specify Yearto Rican,	es or No- etc.)	14. Race - Black,	America White, e	
36	72 hours after death with the Maryland Insturat; or Items 23s or 28s-f show Ideal Examination nutilized at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tyes 2 If Yes, Give Year or Dat	,		1 ☐ Yes 2 ☑ No Specify:					Specify:	white	
21215-0036	tural	ed	15. Decedent's Ed			16a. Dece	dent's Usua	al Occupa	tion		16b.	Kind of Busin		
215	within 72 ene. than "na he Madi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-	4or 5+)	life.	DO NOT u	rk done d se retired)	uring most of w	rorking				
21	filed with Hygiene. other than	S	12			Home	maker					n Home		
nd	be file	Be	17. Father's Name (First, Middle, Last)						18. Mother's N Lydia			n Sumame)		
Maryland	2 should be and Mental Is marked of raumatic eve	ို	Phillip F. Brenner 19a. Informant's Name/Relationship (7)	vne Print)		19b Maili	na Address	(Street a	nd Number or I			or Town. Sta	ate. Zio	Code)
Ma	lith an 27 ls r traus			ghter			-		e Drive			•		
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Macical Examiner must be neitling at once.		20a. Method of Disposition			Place of Dispo	sition (Name	me of other place	9)	Date	20c.	Location - Cit	ty or Tov	wn, State
ш			1 Durial 2 Acremation 3 Removal from State 4 Donation Cher (Specify) 1 Surial 2 Acrematory or other place) Hill Top Serv. Corp 4/23/2007 Towson, I								son, Mar	on, Maryland		
Baltimore,	permit. Departr Importi eny inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214 5305 Harford Road											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	I	1116	UW	um	Ti					Onsot and Dodn
	/Medical Examiner		resulting in death)	Due to (c	or as a conse	quence of):								1
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (a	ras a conse	quanea of):	-						+	VIII
	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.											
Ó,	e exectan ar	Ex	resulting in death) Last	Due to (d	or as a conse	quence of):								
8760,	cate be executed physician and the burial-transit	dical		d									-	
Φ		/Me	IF FEMALE:	23c. If yes, outc	ome of prean	ancv		-				23d. Date of	of delive	rv
Вох	leath certifii attending p	Physician/Me	in the past 12 months?	1☐Live bii	rth 2 ☐ Fet ant at time of	al death 3	□Ectopic p □ Other (s _t					Month		Day Year
o.	at the de by the a	hysi	1 ☐ Yes 20 No 9 ☐ Unknown	9□ Unkno	wn							<u> </u>		-
o,	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions co	entributing to dea	ath but not re	sulting in the u	inderlying o	cause give	en in Part I.	23		_		e cause of death?
Records,	v require been si should I									-	1 🗌 Yes	2 ∐ No 3	☐ Proba	ably 4 Unknown
ec	law r	Completed								- 24	ta. Was an autopsy	pric	re autop or to con ath?	osy findings available appletion of cause of
a H										1.	performed?			2 💢 No
Vital	Physician: 1 rthis certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2]ER/Outpatie	nt 3 D	Othe	26. Place of D		ck only one) Residence	€ □Othor	(Sacotte	
o	g Phy er this	n: To	27. Manner of Death	28a, Date o		28b. Time of		28c. Injury Work			escribe how in			/
ion	Attending For death. •ctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation		1, Day 10ai)	injury	М		Yes 2 □No					
Division	p aff ⊊	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace	of Injury - At I g, etc. (Spec	nome, farm, st ify)	reet, factor	y, office			cation (Street ty or Town, Sta		or Rurai	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	(Check only one) Certifying Ph	reician: To the liner: On the ba and mann	sis of examin	owledge deal ation and/or in	h occurred ovestigation	n, in my op	e data and pla pinion, death oc	curred at t	e to the cause he time, date a	(s) and mann nd place, and	or as st d due to	the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	Hr. 0	MI P	Mus.	29	c. License	onumber	111	29d. 0	Date signed (
)	7		> Wun a	UJUNO	17	11/215	. 24	(15	080	- AL	WH (70	100%
3	•		30. Name and address of person who	completed cause	of Wath (Ite	m 23a) (Type	Print)	2 (sta	425.	2 Ba	Gm.	re	21204
	Sta	ate	31. Date filed (Month, Day, Year)	32.	gistrar's Sign	nature	<i>A</i> .)	, .		,			
	Regist		APR 2 0 2	מחק אחת	and a man	KA	man.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 7 State of Maryland / Department of Health and Mental Hygiene

		- For State	Certificate of De	eath	Reg. N	No	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	7		Date of Death Month Da	ay Year	3. Time of Death
edical Examii		JOHN	JONE		April 18, 200	7	0812 hrs
		4a. Facility Name (if not institution, give street and number)		ity, Town, or Location of Death altimore		4c. County of Death	1/4
		645 North Augusta Avenue			8. Date of Birth(N	AM/DD/VVVVI a Ri-	thplace (State or
Funeral		1.1.5	` '	Under 1 Year If Under 24Hrs Ionths Days Hours Min	⊣ `	Foreig	n i
Director		216-32-5387 1×M 2 F	Yrs.		150.09	1736 co	untry) MARYLANN
>,	ļ	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Location				10d. Inside City Limits
w any		10a. State 10b. County	Toc. City, Town of Location	(Ray-	0= 0:+	-/	1 X Yes 2 No
Maryland 28a-f show d at once.	ġ.	MARYLAND N/A		VOALTIMOI	10g.	Citizen of What Cou	
Mary r 28a- ed at	Director	10e. Street and Number		f. Zip Code	O log.	prinzeri di Wilat Cod	ina y :
ith the Maryland 23a or 28a-f sho notified at once.		645 N. AUGUSTA	AVENUE	2122	, 7	USA 114 Page Amer	ican Indian, Black,
th will the series of the seri	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	If Yes, s	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	ican indian, black,
or dea	副	1 Yes 2	X No	s 2 X No specify:		Specify: BL	ANV
rs afte ural"	ē	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company of the compa		Isual Occupation (Give kind of	work done 16	b. Kind of Business/	Industry
2 hou "nat	ğ	Elementary/Secondary (0-12) College (1-4 or 5	during most of	of working life. DO NOT use ret			
36 hin 7, than cdical	휥	7tHGRADE		TODIAN	1	MINTRI	CIUB
5-0036 led within 77 Hygiene. other than the Medical	Completed	17. Father's Name (First, Middle, Last)	Cuc	18.Mother's Name	e (First, Middle, Mai	den Surname)	
21215-0036 Id be filed within 72 Aental Hygiene. narked other than event, the Medical	Be (ROBERT	TONES	LUCI		WIL	KES
(1 = - = 0	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	dress (Street and Number or	Rural Route Numbe	r, City or Town, State	e, Zip Code)
e, MD 2 l and 2 shou Health and In item 27 is n		CHRISTINE JENNINGS (S	515TER) 8410	LUCERNE RD		LSTOWN P	102/133
9		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposition crematory or other		Date 2	0c. Location - City o	r Town, State
imore, Pages I ar		1 Burial 2 Cremation 3 Removal from Sta		NAL CEME 04	-24-07	LAUREL	- MARYLAND
Baltimor permit. Pages Department of Important: If		1. Si ature of Funeral Service Lice s-	22. Nam	and Address of Facility	BROWN	TR. FUNE	RAL HOME
E F P F W		jaiqueline & Noa	ie 2	78 N. FULTO	NAVE	BALTO.	MD21217
Physician		Part V Inter the disease, or complications that caused failus. List only one cause on each line.	the death. Do not enter the n	node of dying, such as cardiac	or respiratory arrest.	, shock, or heart	Approximate Interval Between Onset and
Medical. kaminer	4	Immediate Cause (Final disease a. Atheroscler	rotic cardiovascu	lar disease			Death
7.4		or condition resulting in death) Due to (or as a conse	equence of):				
	į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a const	equence of):				
	nin	cause. Enter Underlying Cause					
ist H a	Examiner	events resulting in death) Last Due to (or as a conse	equence of):				
760, cate be executed physician and he burial - transit		X UNPENDED AMENDED					
' 60, ate be e physician ne burial	Medical	#4Ja,21, pt	erME, g867, 5/15/	07 TT		23d. Date of delive	D/
876 ifficati ng phy is the		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	ne of pregnancy 2 Fetal (death 3 Ectopic pregr	ancy	Month	Day Year
Box 687 death certification at the attending of the terminal o	icia		P. C. C. C H.	(Specify)			
Bo e deai the at	Physician/	1 Yes 2 No 9 Unknown g Unknown			Loo- Did take	and the contribute to	o the cause of death?
ords, P.O. Bo w requires that the de s been signed by the should be detached fo	by P	Part II. Other significant conditions contributing to deat	h but not resulting in the unde	eriying cause given in Part I.			obably 4 🗸 Unknown
S, F					24a. Was an		autopsy findings available
ords, w requir us been s should	plet				autopsy	prior to	completion of cause of
Rec The la	Completed				1 Yes 2		
Vital Reco hystcian: The law this certificate has al director, page 2 s	Be C	25. Was case referred to medical examiner?		26.Place of Death (Check			
Vit hyste Ithis	To E	1 Yes 2 No Inpatio	ent 2 ER/Outpatient 3	<u> </u>		esidence 6 🗸 Oth	er: Scene
n of \ding Phy.		27. Manner of Death 28a. Date of Inj (Month, Day,)	ury 28b. Time of Injur	y 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	w injury occurred	
ttend death ctor;	atic	2 Accident Investigation			206 1	A and Niverban on F	Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law requirems after dearth. erral Director: After this certificate has been s filled in by the funeral director, page 2 should t	ertification:	Suicide Could flot be	njury - At home, farm, street, f	actory, office building, etc.	or Town, Sta		tural Route Number, Ony
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 24 hours after death. After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans	ပ	4 Homicide	<u> </u>	at the time alone and alone	ed due to the enum/	a) and manner as at	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	ledical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner:	ny knowledge, death occurred imination and/or investigation	at the time, date and place, ar , in my opinion, death occurred	at the time, date an	o, and manner as stand ad place, and due to	the cause(s)
To the To the comp	Medi	and manner stated 29b. Signature and title of certifier		29c. License number		29d. Date signed (M	
	=		A	O.C.M.E.		April 18, 2007	
		I headon M. 17	JR				
-6		 Name and address of person who completed cause of Theodore M. King, Jr., MD. Assistant M 		11 Penn Street, Baltimo	re, MD 21201		
	tate	Decision of the second of the	ar's Signature				
Ponis	تندن	APR 2 0 2087	N Acces	2 -			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 13:42 p. Arthur Johnson III April 17 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months **X**XM 2□ F Maryland 212-42-1109 63 Apr. 10, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 → No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a odical Examiner must b United States 7605 Gum Road Funeral 21222 within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Utility Buyer-BGE permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the any injury or other traumatic event, the second in the control of the con 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Harry Johnson II Clare Shepp 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan M. Johnson (Wife) 7605 Gum Road Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4/19/2007 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovespirator **Physician** disease or condition /Medical Due to (or as a consequence of): **Examiner** pertensi Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria besite Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🕱 DOA ဥ 1 ☐ Yes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier B56466 18 07

Registrar
DHMH 17 Rev 1/2001

State

White

32. Registrar's Signature

Marsh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Blvd

Campbell

31. Date filed (Month, Day, Year)

			1 = For State Registrar	State of Marylan	d / Depa		t of H	ealth ar		ntal Hyg		007	12746
	Diam'r.		1. Decedent's Name (First, Middle, Last)						2.	Date of Deatl	Day	Voor	3. Time of Death
	Physici /Medio		Louis Valentine	Kahmer, Jr.					A	pril	18,	2007	12:45 P M
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location of	Death		4c. Cou	nty of Death	
			9305 Ramblebrook	Road			Balt	imore	2			Balti	more
	Funeral		5. Social Security Number 6. Sex	M 2DE		If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
L	Director		217-01-6880 Usual Residence of Decedent	94	Yrs.				J	an. 11	191	3 M	laryland
	and		10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary f sho	ō	Many land Palt.	imore		Da1	timo						1 ☐ Yes 2 X No
	28a	Director	Maryland Balt: 10e. Street and Number	Imore		10f. Zip		re		10	g. Citizen	of What Cou	intry?
	3e or		9305 Ramblebrook R	Poad.				21236	;		-	S. A.	
	death	nera		12. Was Decedent Ever in U	.S. 13.	Was Deced	ent of His			y Yes or No- an, etc.)	14. F	Race - Ameri	
9	after or ite	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		irres, spec 1 □ Yes 2			Риепо ніс	an, etc.)		Black, White	, etc.
2	urel',	d by	3	Year or Dates:		10 105 2	: [<u>A</u>] 140	Specify.			Spe	cify:	White
21215-0036	72 h "netu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give	kind of wor	k done d	urina most o	of working		6b. Kind o	f Business/Ir	ndustry
12	within so a. than the within the	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us						,	
2	ilied within 72 hours after death with the Maryland Hygiene. yther than "neturel", or items 23e or 28e-f show yth. The Medical Examinat must be notified at	ပိ	12 17. Father's Name (First, Middle, Last)		<u> </u>	Llecti		s Ins	-	or L First, Middle, M		overn	ment
Maryland	d be	Be c	Louis V. Kahmer,	Sr					,	eth M.			
2	should nd Me mark mati	2	19a. Informant's Name/Relationship (Type		19b Mailir	na Address	(Street a			oute Number,			n Code)
e S	nd 2 s lth ar 27 is r trau		Kathleen Hare (Dau								•		nd 21236
ē,	Hea Hea Hem		20a. Method of Disposition		Place of Dispo				Date			on - City or T	
Baltimore,	ent or		1 ☐ Burial 2 🛣 Cremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify)	onioval itolii State	emetery, crer. Lyview			1.0	-20	-^7 B	altim	ore. I	Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23e or 28a-f show entry or other traumatic event, the Madical Examination ust be notified at once.		21. Signature of Funeral Service License							nunek E			
ñ	Depa Impo eny ii		Buin all	ull						ltimore			
	Physician /Medical Examiner pricial italiansit	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and learning Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of): ART								Interval Between Onset and Death
3/60,		icai	d										
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pre		-				Date of deliv Month	rery Day Year
	wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions con		ulting in the ur	nderlying ca	luse give	n in Part I.					the cause of death? bably 4 @Unknown
000	e law req has beer je 2 shou	Completed								24a. Was an		b. Were auto	opsy findings available
ř	The l	Com								perform	ed?	death?	empletion of cause of 2 No
<u> </u>	icien: Th certificate ector, pag	Be (25. Was case referred to medical examiner?							heck only one)		
>	Physicien: this certifica ral director, p	ည	1 ☐ Yes 2 ☐ No		ER/Outpatien	t 3 DO	A Othe	r: 4 🗆 Nursi	ing Home	5 PAesider	nce 6 🗆 🤇	Other (Speci	fy)
Division of Vital Records,	ding h. After fune	ation;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28 M	Sc. Injury Work 1 Y	at ? es 2⊡No		. Describe hor	w injury occ	curred	
DIVIS	after death after death Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory,	office		28f.	Location (Str. City or Town,		mber or Run	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat to the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a	it the time	e, date and pinion, death	place, and occurred a	due to the ca at the time, da	use(s) and te and plac	manner as s e, and due t	stated. o the cause(s)
	o the	Me	29b. Signature and title of certifier			29c.	License	number		29	d. Date sig	ned (Month,	Day, Year)
			Deven R Nol	nun		100	0 25	5010		0	ipul	20,2	2007
	0		30. Name and address of person who con Serena R. NOLAN A		23a) (Type, i	D-i-A)			VILLE				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture 🔺	9				,			
	Registr		APR 2 0 20	32. Registrar's Signa	I A	and I							

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Winifred Loewner **Physician** Month 2007 /Medical City, Town, or Locau...

Randaustown

Under 1 Year | frunder 24 Hrs. | 8. Date of Birth (Month, Day, Year April 10, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Genesis LOUVI Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreig **Funeral** 1□ M XX F Months 78 Director Yrs 1929 Mary land 213-28-0017 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov the Medical Examiner must be notified at 1 Yes XX No Directo MD **Baltimore** Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 246 Galan Rd. items 23a 21228 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married XX Married 5 Baltimore, Maryland 21215-0036 1 Tes XX No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o William A. Sapp Lottie W. Abbott 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mail Affres (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Stanley M. Loewner / Husband 246 Garlan Rd. Catonsville, Maryland 21228 20b. Place of Disposition (Name of comptent, crematory of other place)
New Cathedral
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of H important: if its eny injury or ot once. XXBurial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) April 21,2007 Baltimore, MD 21. Signature of United Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erebrovasc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ been si 3 Probably 4 Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes tirector, page 2 s autopsy 1 Yes 2 0 NO Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 21100 ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after of to the Funeral Direct 4 Homicide 1 Strifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 State 0

Registrar

07-02859 Gregory Littesy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2 Date of Death 3. Time of Death Month Day April 14, 2007 Medical Examiner 1725 hrs 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death 2228 Linden Avenue Baltimore 5. Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY 9/ Birthplace (State or Director Months Foreign Hours Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits Yes 2 No notified at once. Director 10e. Street and Number 10g, Citizen of What Country? 3rd Floo Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married Never Married White etc. 1 Yes If Yes, Give Year Widowed Divorced Yes 2 No specify: "natural" Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life, DO NOT use retired) **21215-0036** ould be filed within 72 ha Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than "traumatic event, the Medical I and 2 should be filed within Health and Mental Hygiene lan 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maider Be 19b. Mailing Address (Street and Number or Rural Route Number, Wie If item 27 is 0 20b. Place of Disposition (Name of cemetery, or other Cremation Pages 1 Burial 2 3 Removal from State Donation 5 Other Specify. 21. Signature of Funeral Service LicerSee art I. Enter the disease, or complication illure. List only one cause on each line **Physician** at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and /Medical Combined methadone and morphine use Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Unidenying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit put Physician/Medical X UNPENDED AMENDED, PII, 27, 28a-f, perME, G868, 6/15/07 TT attending physician or use as the burial certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Fetal death Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ē 1 Yes 2 V No 3 Probably 4 Unknown Cocaine use Completed 24a Was an 24b. Were autopsy findings available autopsy has prior to completion of cause of death? performed? this certificate ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 V Yes 2 No After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending 1 Yes 2 X No 24 hours after death Director: the Fnd 4/14/2007 Fnd 4:40 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide 2228 Linden Ave. Baltimore, MD determined House To the Funeral 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 15, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Sphature State Registrar MPR 2 0 2007

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav Month **Physician** 16:30 PM 2007 Farnando Nicolas Martinez 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALtimore HOSPital Rosedale Franklin Square If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number NI A 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours 3, 2007 Maryland April Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 1 TYes 2X No Maryland | Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 123 Deaver Street U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 X Yes 2 □ No SpecifyMexicanAmerican Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical d 2 should be filed within it and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ALU 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennifer Dienger Martin Martinez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other tranonce. Pages 1 and 2 Jennifer Martinez (Mother) 123 Deaver Street Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-19-2007 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** QValouscy un cavalo disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the death certificate be executed x Vene iding physician and ise as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 ☐ Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed? Yes 2. No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 2 After thi 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after Hospital within 24 hours a (X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 9000 Bedvick wank 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

eth Gabriel M	ntal Hygiene		
Physic		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Year 1425 hrs
Medical Exam	iner	4a. Facility Name (if not institution, give street and number) 4b. City, Towh, or Location	April 10, 2007 1425 hrs
		Upper Chesapeake Medical Bel Air	Harford
Funeral Director		Months Days Hou	der 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign Country)
,		Usual Residence of Decedent	
Maryland 28a-f show any <u>d at once,</u>		10a, State 10b, County 10c, City, Town or Location	10d. Inside City Limits 1Yes 2No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rived other thau "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the 1 23a or notifie	al Dir	102 Waldon Rd., Apt. B 2100 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	rigin? (Specify Yes or No- 14. Race - American Indian, Black,
r death wi or items must be	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	
	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specificates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	DINACCO
21215-0036 Id be filed within 72 hours after dental Hygene. narked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NO	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	omo	17. Father's Name (First, Middle, Last)	er's Name (First, Middle, Maiden Surname)
215. be filed mtal Hy irked of	Be	Richard N. Mosley Gic	ovanna Stacen
ore, MD 21215-0036 s. 1 and 2 should be filed within 72 hours after frequent and Memal Hyggene. If item 27 is marked other than "matural", her franmarie event, the Medical Esaminer.	L L	19a. Informant's Name/Relationship (Type, rint) RICHOLOGICA + GROVAGNA MUSICY - 102 Walcon	Record Route Number, City or Town, St. e, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		4 Donation 5 Other Specify: Jarrettsville (enuteru	4/20/07 Jarrettsville, MD
Bal permi Depar Impo		21. Signature of Funeral Service Licensee 22. Name and Address of Facil	napely Cromation Services - Bel Air
Physician /Medical		23a Part I. Enter the lisease, or complications tha caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a	Death
	F	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or Injury that mittaled	
executed an and al - transit		d.	
), be exe sician urial -	ledical	X UNPENDED AMENDED #23a, 27, 28a-f, perMF, 9867, 5/29/07	TT 23d. Date of delivery
ox 68760 eath certificate b attending physic for use as the bu	sician/Me	past 12 months?	pic pregnancy Month Day Year
Box 68760 e death certificate be the attending physied for use as the bu	Physic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	
	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death. The an Director After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed		24a. Was an autopsy findings available prior to completion of cause of
tal Recol	ldmo		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rec ician: The certificate	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4	h (Check only one) Nursing Home 5 Residence 6 Other:
n of Vir ding Physic After this funeral dir	1: To	1 Ves 2 No Enjury at Wo 28b. Time of Injury (Month, Day Year)	
Sion Attendir death. ctor: A	ation	Natural 5 Pending Fnd 4/10/2007 Fnd 1:14 pm	
Divisital or Aus after	Certification:	3 Suicide 6 Could not be determined (Specify) Sind:residence	102 Waldon Rd Apt B Abingdon, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director A completely filled in by the fit	cal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and property one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	place, and due to the cause(s) and manner as stated.
To th within To th	Medical	29b. Signature and title of certifier 29c. License number	
A		O.C.M.E.	April 11, 2007
0		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201
8	tate	To State at	

DHMH 17 Rev 1/2001

ORIGINAL

Grace McQueen		- For State	Sta	ite of Maryla		rtment of <i>tificate of</i>		d Mental F		og No		and a real section from
Physician	/	Registrar 1. Decedent's Name	(First, Middle	,Last)					2. Date of Dear	Day Yes		3. Time of Death
Medical Examine		Grace 4a. Facility Name (if		-:	Mae		McQueer	Location of Dea	April 14, 2	007 4c. County		1230 hrs
	ı	3505 Menlo		, give street and no	iliber)	ľ	Baltimore	Location of Dea	ui	4c. County	OI Death	
Funeral	- 1	5. Social Security N		6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea			th(MM/DD/YYYY	y) 9. Birth Foreign	
Director	L	142-24-6		1 M 2 X F	77	Yrs	Months Day	rs Hours Mi	07 0	2 29		ntry) NC
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locat	on					10d. Inside City Limits
and show a	5	MD	N	7	В	altim	ore					1 X Yes 2 No
the Maryland a or 28a-f sh tified at once	ב ב	10e. Street and Nun					10f. Zip Code		1	0g. Citizen of W	hat Count	try?
ath with the Maryland items 23a or 28a-f show any last be notified at once.	<u>8</u> -	3505 Me	erlo A		edent Ever in U.S	C 12 W/a		L215	Specify Yes or No		S.A.	can Indian, Black,
feath w		1 Never Marrie	d 2 Ma	Armod Fa				n, Mexican, Puer			te, etc.	arr malari, Diack,
s after d	-	3 X Widowed		rced If Yes, Give Yea or Dates:	г		Yes 2 X No			Specify:		.ack
72 hours n "natural Exam		15. Decedent's Edition Elementary/Second		fy only highest grad				ition (Give kind o e. DO NOT use re		16b. Kind of B	usiness/In	ndustry
5-0036 led within 7 Hygiene. other than the Medica		12th gra		4yr		Po.	licewon	nan		U.S.	Gove	rnment
filed w filed w Hygie of othe		17. Father's Name (Last)					ne (First, Middle, I	Maiden Surname	∍)	
2121 Muld be fi Mental J marked t event,		Robert F 19a. Informant's Nar		ip (Type, Print)		19b. Mailing	Address (Stre		Rural Route Nur	nber, City or Tov	wn, State,	Zip Code)
MD d 2 sho d 2 sho lth and in 27 is numati	-	Vivian E		-Niece					, Camde			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If tiem 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disp 1 X Burial 2		3 Removal fro			ition (Name of ce ner place) B ibli c		Date	20c. Location	- City or	Town, State
timent rtant:		4 Donation 5 21. Sonature of Fur			Ga	rdens	Cemete lame and Addres	rv 14/	23/200	Rale	igh,	NC
Bal permi Depa Impo injur	- 11	17/1/	1/1	// /	-	l Ma	arch F	H West		-imaka	. ма	21215
Physician	1	Z3a. Part 1. Enter the failure. List only	e disease, or	complications that con each line.	aused the death.	Do not enter t	ne mode of dying	, such as cardiad	or respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
/Medical xaminer	i	Immediate Cause (For condition resulting	inal disease	a. Atheroscler			ease					Death
همر	-	Sequentially list con		b	consequence of	ŋ:						
		if any, leading to im cause. Enter Under	mediate	Due to (or as a	consequence of	f):						
lisit ed	אם 	(Disease or injury the events resulting in contact the		Due to (or as a	consequence of	f):				. –		
Avision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit policial Certification: To Be Completed by Dureirian Medical Examiner	<u></u>	UNPENDED		d AMENDED						-		
760, ficate be g physici the buri		IF FEMALE:	pregnant in th		outcome of pregr					23d. Date o		
Box 687 e death certifice the attending p ed for use as th	2	past 12 months'	?	4 Pregn	ant at time of		tal death 3 her (Specify)	Ectopic preg	inancy	Month	D	ay Year
Bo he deat to the at the at hed for hed for	<u></u>	1 Yes 2 V N		g Unkno	own	- del - la aba		-bi- Pti	220 Did t	ahassa usa sast	tributa ta	the cause of death?
Vision of Vital Records, P.O. or Attending Physician: The law requires that the ceath. Director: After this certificate has been signed by in by the funeral director, page 2 should be detach.	3	Part II. Other signif	icani conuiti	ons contributing to	death but not re	esulting in the t	inderlying cause	given in Part i.				ably 4 Unknown
Records, The law requires ficate has been signage 2 should be	מובו								24a. Was			topsy findings available ompletion of cause of
eco he law ate has										rmed? 2 ✔ N	death?	
tal Reccian: The certificate ector, page	וע	25. Was case referrexaminer?	ed to medical				26.Plac	e of Death (Chec	ck only one)			
f Vit	2 [2 No			ER/Outpatient		Other Nur.	sing Home 5	Residence 6		: Scene
on of or anding Plats. The funeral Higher of The Funeral Higher of		1 V Natural	5 Pend		, Day,Year)	200. Time of	· · · _ ·	Yes 2 No	200. Describe	now injury occu	ieu	
Vision o spital or Attending hours after death. neral Director: Aft filled in by the fune	2	2 Accident 3 Suicide		not be 28e. Plac	e of Injury - At ho	ome, farm, stre	et, factory, office	building, etc.	28f. Location (ber or Ru	ral Route Number, City
spital hours a neral J filled	5	4 Homicide		mined (Specify)					1			
Vision of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for Modical Contribution: To Be Completed by Physician	<u> </u>	(Check only	Certifying Ph Medical Exar	ysician: To the bes	of examination ar	ge, death occu nd/or investiga	red at the time, o tion, in my opinio	late and place, a n, death occurre	nd due to the cau d at the time, date	se(s) and manne and place, and	er as state due to the	ed. e cause(s)
To Will		29b. Signature and t	title of certifier	and manner s	tateu.		29c. Licen	se number		29d. Date sig	ned (Mor	nth, Day, Year)
		Cah	il	14			0.0	.M.E.		April 16, 2	:007	
\triangleleft		30. Name and addre Zabiullah Ali		who completed caus assistant Medic	·		n Street, Bal	timore, MD 2	21201			
Stat	~	31. Date filed (Monti	h, Day, Year)	32.	gistrar's Signatu	re 🤌						
Registra	ľ		PR 2 0	2007	MUKEN L	r 600	afa s					

			State of Maryland / Department of Health and M	lental Hy	giene	17	12752
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	U I	3. Time of Death
	Physic		FLORENCE MORRISON	Month	Day 13 7	Year	4 AN
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	7	4c. County	of Death	
			Good Samaritan Houpital Baltimore			VIA	
	Funeral Director		5. Social Security Number 136 18 -3146 1 M 2 F 7. Age (In yrs. last birthday) 15 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th av. Year) 1921	9. Birthp Cour	place (State or Foreigntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	h tha Marylan r 28a-f show .notified at	tor	MD N/A BACTIMORE				1 Pxes 2 □ No
	with the same	Funeral Director	10e. Street and Number 522 (ANTHONY AVE 21204		10g. Citizen of V	What Cour	ntry?
Maryland 21215-0036	hours after death unel, or items 23.	by	11. Marital Status 1	ecify Yes or No Rican, etc.)		e - Americk, White,	
5-0	72 mat	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ing	16b. Kind of Bu	usiness/Inc	dustry
121	i within jiene. r then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Flom E MAKER		DON	ues	TIC
d 2	Hyg Hyg the	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle	, Maiden Suman	10)	
ylar		To E	UN KNOWN IRENO		MORRIS		
	h ar h ar reu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura. 50 YCE MORRISON - Daughter 5721 ANTHONY KIE Br.	al Route Numb FCTIMBR	er, City or Town, ら、Mカ ユ	State, Zip	Code) ≨
Baltimore,	ges 1 and t of Healt tf item 2 or othar		20a Method of Disposition / 20b. Place of Disposition /Name of ' D	Date	20c. Location -	City or To	own, State
ţ	r it		'4 □Donation 5 □ Other (Specify) ROSE #1/1 CEM1.	101	LINDER	N	ر.
Bal	permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ph. 1721-21 N. Monro E St.	ulips :	tunere i	Hom	Uthen
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of) = 2	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Onset and Death
	/Medical		resulting in death) Due to (or as a con equence of):				The day
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Euclowetral (aucr Due to (or as a consequence of):				2006
\$	utad Insit	miner	cause. Enter Under vind. Cause (Disease or injury				
<i>h</i> .	be executad ician and burial-transit	Exami	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
68760,	cate be e physician the buria	edicai	d				
	the Contract		IF FEMALE:				
Вох	eath certif attending tor use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1		23d. Dat Mo	e of delive nth	ory Day Year
P.O.	at the de by the tached	hysi	1 ☐ Yes 2 1 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
	the page	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use conti	ribute to th	ne cause of death?
Records,	w requires to been signates should be		oltaretes wellitus	1 🗆 '	Yes 2□No	3 🗌 Prob	ably 4 Munknown
eco	aw as b 2 st	Completed	coronary artery dissease	24a. Was autoj	an 24b. V	Vere auto	psy findings available apletion of cause of
a F	Th ate pag		leg word	1 ☐ Yes	21 No 1	death?	2□ No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom				
) of		—	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		how injury occurr		/)
ior	Attending F r death. sctor; Atter by the funera	atio	2 Accident investigation M 1 ☐ Yes 2 ☐ No				
Division of	al or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or Tox	Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ed at the time,	cause(s) and ma date and place, a	nner as st	ated. the cause(s)
	orthe Mithin To the Comple	Me	29b. Signature and title of certifier // 29c. License number		29d. Date signed	d (Month, i	Day, Year)
	- > - 0		11the No 20052583		Apri	A 13.	7-005,
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarid J. Naman, no 5601 Loch Raven	Blue	l. hal	ltm	20.440
				, , , , , ,	. ,	- ,	2(239
	Sta Registr		APR 2 0 2007				
DH	MH 17 Rev 1/2	001	Lanner Dr. Harres				
			ORIGINAL				

		•	1 - State of N	•	artment of Health and I rtificate of Death		ene 2007	12753
ľ	* 9		Decedent's Name (First, Middle, Last)			2. Oate of Death		3. Time of Death
B	Physici		Julia Miotla			April 18	Day Year 2007	7:15 a. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	or)	4b. City, Town, or Location of Death		4c. County of Death	
T		× 5	1618 D Swallow Crest Driv	e	Edgewood		Harford	
uğ.	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	Year) 9. Birthp	place (State or Foreign htry)
	Director		215-52-1928 1 M 2X F	85 Yrs.		Apr. 1,	1000	aine
	and *	1	Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Aaryl.	ច	Maryland Harford	Edgewoo	đ			1 Yes 2 No
	28a-	Director	10e. Street and Number		10f, Zip Code	100	g. Citizen of What Cour	ntry?
	Mith Sa or		1618 D Swallow Crest Driv		21040		nited State	,
	ns 2:	Funerai	11. Marital Status 12. Was Decede		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ	an Indian,
ω.	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23e or 28e-f ehow avent, The Medical Exercities must be notified at	교	Armed Force	No		o Rican, etc.)	Black, White,	
5-0036	ral', o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Date	s:	1 ☐ Yes XXNo Specify:		Specify: Wh:	ıte
2-0	72 honatu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking 16	6b. Kind of Business/Inc	dustry
2	ithin	npi	Elementary/Secondary (0-12) College (1-4c	or 5+)	,			
7	filed within 72 Hygiene. other than "na ant, the Medic		5 years	Ho	memaker		Own Home	
and	be fi	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	aiden Sumame)	
$\frac{3}{2}$	should be nd Mental marked o	2	Unknown 19a. Informant's Name/Relationship (Type, Print)	405-44-10	Unknov		0.4	0-41
Maryland	d 2 sho			m\	ng Address (Street and Number or Ru	mar modite indiriiber, t	City of Town, State, 21p	(Code)
	as 1 and 2 should bot Health and Ment of Health and Ment item 27 is marked r other traumatic a		Joseph W. Miotla, Jr. (So 20a. Method of Disposition	20b. Place of Dispo	Steven Drive		Maryland Oc. Location - City or To	
5	Pages nent of int: If it iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te cemetery, cre	matory or other place)	4		
Baltimore,			4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee		islaus Cem. 4/2 2. Name and Address of Facility	21/2007	Baltimore	, Maryland
ä	Departr Imports any inj		16.1-66	D	uda-Ruck Funeral	Home of D	undalk, Ind	3.
			23a. Intl. Enter the disease, or emplications that caus shock, or heart failure. List only one cause on each	ed the death. Do not en	922 Wise Avenue fer the mode of dying, such as cardiac	Dunda Lk c or respiratory arres	Maryland 2.	Approximate
	Physician		Immediate Cause (Final	-		11	- 1	Interval Between Onset and Death
81	/Medical		disease or condition resulting in death) Due to (or	as a consequence of):	Cudiony	an		
	Examiner)		
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
	cuted	Examiner	that initiated events C.					
Ď,	e exe		resulting in death) Last Due to (or	as a consequence of):				
8/60	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial transit	dicai	d					
Ø X	eath certific attending p	Mec	IF FEMALE:					
ХOЯ	attenc attenc	lan		2 Fetal death 3	Ectopic pregnancy		23d. Date of delive Month	ery Day Year
o.	at the de by the a	by Physician/Me	1 Yes 2 No 4 Pregnant 9 Unknown 9 Unknown		Other (specify)			
٦.	res that tigned by	F.	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
Hecords,	uires I sign Id be					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Ö	w require been sign	ete				24a. Was an	24b Were auto	nsv findings available
	: The lav	Completed				autopsy	ed? death?	psy findings available mpletion of cause of
Vital		a	25. Was case referred to medical		26 Place of Dec	1 ☐ Yes 2 [ath (Check only one)	No 1 Yes	21No
	ysician: is certific director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Outpatier	Othor		ice 6 Other (Specific	v)
Division of	g Physie ter this neral di		27. Manner of Death 28a. Date of It			28d. Describe how		,,
0	ttending death. ctor: After y the funer	atic	2 Accident investigation	anjury	M 1 Yes 2 No			
≝	2 5 0	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, str etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
	ital o rrs aff ral Di							
	Hospital or 24 hours afte Funeral Div tely filled in	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the besis and manner	of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cau irred at the time, dat	ise(s) and manner as si e and place, and due to	tated. the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Med	29b. Signature and title of certifier	stated.	29c. License number	290	d. Date signed (Month,	Day, Year)
	->-0		Dan(50		03275	5	pril 19 3	1007
1	, 1		30. Name and address of person who completed cause of	f death (Item 23a) (Type,		/ //	131.11/4	
$\underline{\mathcal{L}}$)		Dav. DS Donn	6-5W.	nocPhail Bel	ar ma	7	
Total Control	Sta Registr	_	A	strar's Signature	,			
100	registi	al	ADD an anna la	M M.	M - 0			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2007 **Physician** 19, Carl Edward Nelson, Sr. April 2:20 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Bel Air Nursing Home & Rehab.

5. Social Security Number | 6. Sex | 7. Age (In y Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 Q M 2 □ F Hours Director 77 31, 1929 022-22-2597 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner many 1. 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 XNo Director Maryland Bel Air Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 8 Pequot Drive United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distributing Company Sales Person 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice O'Leary Edward Nelson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, Maryland 21014 8 Pequot Drive Jean M. Nelson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/21/2007 Baltimore, Maryland Oak Lawn Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SHIS Parknes's /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform page certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No Certification: To 2 ☐ ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of 3 att 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ul Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 218 old Emmorten 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William T. O'Keefe 04 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner obedale pital Center timore uare. 8. Date of Birth (Month, Day, Year) 10/03/1924 Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In yrs. last birthday) Days 1 3 M 2 □ F 82 Maryland 216-14-4982 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2 No Baltimore Parkville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2909 Conroy Ct. 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) supervisor mass transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas O'Keefe Agnes Wehage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ottolee P. O'Keefe/wife 2909 Conroy Ct. Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens April 20c. Location - City or Town, State 20a. Method of Disposition 21 1 Burial 2 □ Cremation 3 □ Removal from State 2007 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Free eral Service Lice 22. Name and Address of Facility
Evans Funeral Chapel
& Cremation Services 8800 Harford Parkville, MD Rd. 21234
Approximate
Interval Between
Onset and Death Fact . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final listenoselour cornery artery disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or selectiones of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Hospital

Funeral

Director

28a-f show

notified

a or 23a

Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must

Department of Important; If It any injury or o once. ō

Physician

Examiner

/Medical

burial-transi and

attending physician for use as the buria

ed by the a detached f

signed by the

peen

has

certificate

funeral director,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After I completely filled in by the funers

State Registrar

Kows-Louge MD 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

7602 BBZAIN egistrar's Signature

and manner stated.

Meron Kindluck MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number

D21022

tito MD 21236

29d. Date signed (Month, Day, Year)

4-19-07

Certificate of Death

			1. Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of Death
3,	Physici /Medic		Harold Wayne Rober	cts				April 1	.8 , 20	07	10:45А. м
	Examin		4a. Facility Name (If not institution, give Greater Baltimore		c		r Location of Death OWSON			c. County of Death altimore County	
	Funeral Director		5. Social Security Number 6. Se 215–28–1368	x 7. Age (<i>In yr</i> s. <i>I</i> a M 2□ F 75	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 2	th 17. Year) 20,19	9. Birth Cou Mar	place (State or Foreign ntry) Yland
	pu ,		Usual Residence of Decedent	10c City	Town or Loc	pation					10d. Inside City Limits
	arylaı show d at	_	10a. State 10b. County								1 ☐ Yes 2 🕍 No
	he M 28a-f otifie	ectc	Maryland Baltimore	e country co	ckeysv	_	-		10a Citi	zen of What Cou	ntn/2
	with the	ä	10e. Street and Number 10607 Virginia Ave	anua		10f. Zip Code	1030		-	ed State	
	sath is 23	era	_		13 V			ecify Yes or No		14. Race - Ameri	
	ter de item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S Armed Forces? 1 △ Yes 2 ☐ No	i		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	etc.
336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	∐Yes 2⊠ No	Specify:			Specify: [W]	nite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occup	pation during most of work	dina .	16b. Ki	nd of Business/Ir	ndustry
21	ithin 7 ne. nan "1	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L		during most of work d)	9	_	ale Ema	larrad
	ed wi ygier yger th	ပ္ပံ	12	n/a		Constru		o /Firot Middle		Self Emp	royea
gu	be fill ntal H od oth	8	17. Father's Name (First, Middle, Last) Harolã Roberts				18. Mother's Nam Eva Mari			Surname)	
ž	d Mel marke	힏	19a. Informant's Name/Relationship (7)	pe. Print) (Wife)	10h Mailin	a Address (Street	and Number or Rus			r Town State 7	n Code)
Maryland	d 2 sl th an 17 is r traur		Mrs. Mary Margare				Virginia		-		,MD.21030
	Heal Heal tem 2		20a. Method of Disposition			sition (Name of natory or other pla	00) 3	Date	20c. Lo	ocation - City or T	own, State
Baltimore,	Pages ent of nt: If I		1 Burial 2 Cremation 3 l 4 Donation 5 Other (Specify,	Tellioval Ilolli State []	aney V	alley Me	April 200		Timo	onium, M	aryland
aĦ	mit. I partm sortai / injur		21. Signature of Funeral Service Licens		1 132	Name and Addre	ess of Facility	res Fune			
m	permi Depar Impor any ir		Why of	I- jar, P	2 23	325 York	Road Ti	monium,	, Mar	ryland	on Ctr.,P.A. 21093
3.0			23a. Part . Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final								Onset and Death 5 days
1	/Medical		resulting in death)	a. <u>sepsis seCON</u> Due to (or as a conseque	ence of):						
įr	Examiner	_	Sequentially list conditions,	b. respiratory Due to (or as a consequence)		ire secor	ndary to	COPD			2 days
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				. 1	. 0. /			2 days
	xecul and	xan	that initiated events resulting in death) Last	c. Due to (or as a consequence	ence of):	α	ocarch	08-7			ac cays
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	lan/Medical Examiner	l	d							
89	tificati g phy as the	ledi		· ·							
ŏ	h cert endin use	N/N	23b. was decedent pregnant	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	v			23d. Date of deliv	
	ed for		in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	ath 5	Other (specify)	,			Month	Day Year
P.0	at the	Phy	9 Unknown		N::		ren in Deat I	Ogo Did	tohasso	ios sostilbuto to	the cause of death?
	requires that the de een signed by the a nould be detached t	Completed by Physic	Part II. Other significant conditions co				ven in Fait i.			A	bably 4 Unknown
O.C.	requi	sted	<u>diabetes</u> , anemi	a, acute renal	raili	ire					
3ec	e law has b	nple						24a. Was		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
E	i: The							1□ Yes	2 No	1 ☐ Yes	2 □ No
Ĭ.	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea				
o	Phys r this ral dii	<u>ا</u> ـــ	1 ☐ Yes 27 No 27. Manner of Death	I Inpatient 2 E	R/Outpatien 28b. Time of	I SU DOA	4 Li Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Spec	ify)
Division or Vital Records,	Attending r death. ector: After by the fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Inju Wo M 1	rk?]Yes 2∐No		,	,	
/isi	Atter r deal ector	lica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Street ar	nd Number or Ru	ral Route Number,
Ö	al or safte	Sert	4ITOINIcide	building, etc. (<i>Specify</i>	,			City of 10	WII, SIAIE	=)	
	ospit hour unera	cal (vsician: To the best of my know							
	To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical Certification: To	one)	and manner stated.				T			
	To To	2	29b. Signature and title of certifier	Ones han		29c. Licens			29d. Da	te signed (Month)	, vay, Year)
	11.			RAM, MD			0820		1/6	100	<i>†</i>
1	11%		30. Name and address of person who o	•			De1::	MID 010	0.4		
1		ate	Raya Massoud, M. 31. Date filed (Month, Day, Year)	D 6565 N Cr 32. Registrar's Signat	<u>larles</u> ure —	street,	Baltiore	MD 212	Ocī		

DHMH 17 Rev 1/2001

State

Registrar

APR 2 0 2007

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Isabell Jean Rice Appril 149ay 2007Year **Physician** /Medical 4b. City, Town, or Location of Death Hanover 4c. County of Death Anne Arundel 4a Eacility Name (If not institution, give street and number)
1351 Ridge Commons Blvd Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign TXountry) . Social Security Number 465-46-0732 6. Sex 7. Age (ys. last birthday) **Funeral** 8. Date of Birth 1/9-33 Days Hours 1 □ M 2 7 F Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow th and Menial Hygiene. 17 is marked other than "natural", or flema 23a or 28a-1 ahov traumatic avant, the Medical Examinar must be notified at MD Anne Arundel Hanover 1 Yes 2 No Direct 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code -1351 Ridge Commons Blvd. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b-Kind of Business/Industry Operator Supervisor Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
Walter Plant 18 Mother's Name (First, Middle, Maiden Sumame)
Bertha Jane Cowan Be 2 19a Informant's Name/Relationship (Type, Print)
Mr. Caryll Rice/Son 195 Mailing Address (Street and Number of Bural Boute Humber City of Town State 76 969 Depertment of Health a important: if item 27 is any injury or other tra Apr 20 2007 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Beltsville, Maryland Chesapeake Crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2Rapp Runeral Figuremation Services 21. Signature of Funeral Service License 933 Gist Ave. Silver Spring, Maryland 20910mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): resulting in death) /Medical Examiner bowel bstruction Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Endometrial Stroma Sarcona Metastatic that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy perform No No 1 ☐ Yes 2 ☐ No 1☐ Yes or Attanding Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 fnpatient Other: 4 Nursing Home SX Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerei Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier completely (Crieck only one) 29b. Signature in title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057659 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) M.D. Bieligk Hospital Dr. Glen Burnie, MD 21061 305 Hos 32 Hogistrar's Signatute APR 2 0 31. Date filed (Month State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

William Francis Ris	sch, Jr.	State of Maryla	ind / Departr		Health and		Hygiene	•	07 1275				
Physician/	Registrar	Middle,Last)	Certin	cate or i	Jean		2. Date of Dea	eg No.	3. Time of Death				
Medical Examine		FRANCIS RI	ISCH JR.				Month April 14, 2	Day Year 2007					
	4a. Facility Name (if not ins		mber)	41	City, Town, or	Location of De	ath	4c. County o	f Death				
	793 West Belair A		7 1 - 41 - 1 11		Aberdeen	Licitate	O. To para sepis	Harford	Lo Birth I (Oi)				
Funeral Director	5. Social Security Number		7. Age (In yrs. last b		If Under 1 Year Months Days		vlin.	·	9. Birthplace (State or Foreign MARYLAND Country)				
	216-92-9508 Usual Residence of Decede	1 X M 2 F		42 Yrs.			05/17	/1964	Country)				
any	10a. State 10b. Co		10c. City, Tov	vn or Locatio	า				10d. Inside City Limits				
show unce.	MARYLAND	HARFORD CO		ABERD	EEN				1 Yes 2 X No				
the Maryland a or 28a-f sh iffied at once	10e. Street and Number		<u>.</u>		10f. Zip Code		1	0g. Citizen of Wha	at Country?				
ith the Maryland 23a or 28a-f show notified at once.					21001			U.S.A.					
death with	11. Marital Status 1 X Never Married 2	Married Armed Fo	edent Ever in U.S. prces?		Decedent of His s, specify Cuban		Specify Yes or No erto Rican, etc.)	- 14. Race - White	- American Indian, Black, , etc.				
ter dez	- 2 Widowod 4	1 Yes Divorced If Yes, Give Year	2 X No		es 2 X No	specify:		Specify:	WHITE				
urs aft turral" amine	15 Decedents Education	or Dates:		a. Decedent's	Usual Occupati	on (Give kind		16b. Kind of Bus					
5 72 ho ra Es cal Es	Elementary/Secondary (0-12) College (1	-4 or 5+)	during mos	st of working life.	DO NOT use	retired)						
5-0036 lited within 72 hour Hygiene. other than "natt the Medical Exam Completed.	12th grade	lyr		RED C	ROSS VOI			KUSAH					
215-(be filed on that Hyg risked oth ent, the ent, the			/ A.T.D. I	-			me (First, Middle, I	,					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important I littem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	GEORGE TA 19a. Informant's Name/Rela	KASHI SHIMIZ ationship (Type, Print)	O (STEP I	TATHER 19b. Mailing) Address (Street		NICE SHII or Rural Route Num		n, State, Zip Code)				
MD d 2 sho lth and th and an 27 is numati	H. BERNICE S	HIMIZU/Mothe	er	962 E	dmund St	., Abe	rdeen, M	aryland	21001				
re, l s 1 and f Heal If item	20a. Method of Disposition 1 X Burial 2 Crer	nation 3 Removal fro	•	e of Dispositi natory or othe	on (Name of cen	netery,	Date	20c. Location -	City or Town, State				
Pager Pager nent o	4 Donation 5 Oth	er Spec)fy:	5-09-07	ARLINGT	ON, VIRGINIA								
Baltimore, permit. Pages 1 an Department of He Important: If ite	21. Signal to of Fungtal Se	vice Licensee		22. Na WM	me and Address C. BROWN	of Facility	ITY FUNE	RAL HOME	-HARFORD, P.A.				
	23a Peri I Enter the dispar	e or complications that ca	sused the death. Do	1321	S. PHII	LADELPH	IA BLVD,	ABERDEE	N, MD 21001				
Physician / Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Head Approximate Intervent Between Onset are Death												
Examiner	Immediate Cause (Final dis or condition resulting in dea		consequence of):	пеац									
	Sequentially list conditions	Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):											
ine	If any, leading to immediate Due to (or as a consequence of):												
led (C/C)	(Disease or injury that initial events resulting in death)	ited	consequence of):										
be executed be in a sician and initial - transit edical Executed		d											
O, e be e; ysiciar burial	UNPENDED	AMENDED						Tool B	1.5				
Box 68760 e death certificate to the attending physical for use as the brush state to the state but	IF FEMALE: 23b. Was decedent pregnar past 12 months?	at in the 23c. If yes, o	outcome of pregnand irth		Ideath 3 [Ectopic pre	gnancy	23d, Date of o Month	Day Year				
OX 6 sath cer attendi for use	1 Yes 2 No 9	Haliagura	ant at time of death	5 Othe	er (Specify)			1					
D. BC the destribe by the a	Part II. Other significant c	9 Unkno		ting in the un	derlying cause o	iven in Part I	23e. Did to	obacco use contrib	oute to the cause of death?				
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate there this certificate has been signed by the attending physimenal director, page 2 should be detached for use as the burn: To Be Completed by Physician/Me	\$,,		1 Yes	s 2 V No 3	Probably 4 Unknown				
Records, The law require. Figure has been signage 2 should be completed							24a. Was		/ere autopsy findings available				
e law e has le e has le mol							autop perfo 1 ✓ Yes	rmed? de	rior to completion of cause of eath? Yes 2 No				
Division of Vital Records, rate death or Attending Physician: The law requires at the death of the training the series of the fine or the fameral director, page 2 should be reflication: To Be Completed.		edical			26.Place	of Death (Che	لتتا	2 100	Yes 2 No				
Vital sysician this cert directo	1 Yes 2 No	Hospital: 1	npatient 2 ER	/Outpatient	3 DOA	Other Nu	rsing Home 5	Residence 6	Other: Scene				
n of Villing Phys After this funeral di		28a. Date FOUND	of Injury 28i Day,Year) 50	b. Time of Inj DUND:	· I	y at Work?	28d. Describe Subject sho	how injury occurre	d				
Sion ttend death ctor: y the f	1 Natural 5 2 Accident	Investigation Apr 14, 2	2007 16	01 hrs		es 2 🗸 No							
Division o spital or Attending rours after death neral Director: Aft filled in by the fune Certification:	3 Suicide 6	Could not be	e of Injury - At home	, farm, street	factory, office b	uilding, etc.	or Town, S	State)	r or Rural Route Number, City 206, Aberdeen, MD				
ospita hours unera ly fille	Z9a Certillei	ng Physician: To the bes	Hotel/Motel	death occurre	nd at the time, da	te and place							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death from the Funeral Directors. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	(Check only one) 2 Medica	I Examiner: On the basis of	of examination and/o										
witi To con	29b. Signature and title of c	and manner si	tated.		29c. License	e number		29d. Date signe	d (Month, Day, Year)				
	Calcur	UTV C	/		O.C.N	M.E.		April 15, 20	07				
	30. Name and address of p												
15	Zabiullah Ali, M.D	als:		111 Penn	Street, Balti	more, MD	21201						
State Registra		2 0 2007	gistrar's Signature	Appen									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 18, Year **Physician** Mary Elizabeth Rackensperger 9:35 P. M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day,) August 2, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 177-01-3687 1 ☐ M 2**XX**F 89 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int if Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me ical Examiner must be notified at N/A Maryland Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Westfield Avenue 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White ρ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered Nurse 17. Father's Name (First, Middle, Last) Harry Ferri 18. Mother's Name (First, Middle, Maiden Surname) Be Carmina Stravino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Westfield Avenue Baltimore Maryland 21214 Terri Tartal / Daughter Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/21/07 Baltimore Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road 21. Signature of Funeral Service Licensee Baltimore Maryland 21214 hustina Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Ca disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ hvillate 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1∏ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier N. Chroles St. Balto Md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 19 19 **Physician** 2007 April 10:10 AM Lois W. Regus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Sunrise 8. Date of Birth (Month, Day, Year)
Sept 22,1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗶 F Ohio Director 377 12 3816 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 Tyes 2 No Director Columbia MDHoward 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 United States 6500 Freetown Road Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Heatth and Mental Hygiene. int: If item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Church Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcia Wylie Lowry Drake 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7549 Red Cravet Court Columbia, MD 21046 John LaClere/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If 4-20-2007 Metro Crematory Catonsville, MD Injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 any 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ DEBILITATION 1 Tyes 2 No 3 Probably 4 Unknown Completed INTERSTITIAL PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s After this certificate has 1□ Yes 2▼ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Stother (Specify) asst. live. 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. al or Attend after death. 2 Accident completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

12

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

VALI

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO052861

PIKE CLARKEVILLE

29d. Date signed (Month, Day, Year)

April 19, 2007

MD 21029

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 18 April 2007 2:26 A.M Ronald Richard Schoenberger 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore County The Gilchrist Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 18,1941 5. Social Security Number 7. Age (In yrs. last birthday Days Hours Min. 65 214-40-3360 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No N/AParkville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3221 Chesley Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∕17/Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Calibrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard William Schoenberger Elma May Burkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 3221 Chesley Avenue Parkville, Maryland 21234 Mrs. Shirley Ann Schoenberger 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel Apr. 19, 2007 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr.P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cars disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner The law requires that the death certificate be executed

permit. Pages 1
Department of H.
Important: If Iter
any injury or ott

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

မ

Funeral

Director

s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

al Hygiene. I other than "natural", or items 23a event, the Medical Examiner must t

Examiner Completed by Physician/Medical

Be

Certification: To

Medical

physician and s the burial-transit attending | for use as ed by the detached been signed be should be deta page 2 s has certificate this the Funeral Director: After the mpletely filled in by the funeral

Division or Vital Records, P.O. Box 68760

or Attending after

the Hospital within 24 hours

ပ

	■d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3□Ectopic			23d. Date of delivery Month Day	Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying しくとんらせ	cause given in Part I.		o use contribute to the cause 2 ☑No 3 ☐ Probably 4	
				24a. Was an autopsy performed'		gs available of cause of
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ □	Other:	ath (Check only one)	6 Other (Specify)	s nite
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		30.00
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, facto y)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Nate)	lumber,
	nysician: To the best of my kno niner: On the basis of examina and manner stated.					se(s)

29c. License number

29d, Date signed (Month, Dav. Year)

holes St. Balto. Md Zizox

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

who completed cause of the (Item 23a) (Type, Print)

MARGARET STILLINGS

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division or Vital Records, P.O. Box 68760,

	-	For State Registrar	State of Ma	ar yrama :		tificate					Reg. No	20	07	12763	1
Physicia		1. Decedent's Name (First, Middle, La: Margaret Ellen St								2. Date of D Month April	Death Da 18	y 2	Year 2007	3. Time of Death 9:50 Р. м	
/Medic Examin	_	4a. Facility Name (If not institution, give Stella Maris Hosp				4b. City,		Location	n of Death			. County of	of Death	County	
Funeral Director		214-26-7432	ex 7. Age	e (In yrs. lasi 87	t birthday) Yrs.	If Under Months		If Unde Hours	er 24 Hrs. Min.	8. Date of E (Month, I May 1	Da <i>y, Year)</i>		9. Birthpl Coun Mary	lace (State or Foreign try) 'land	
ylarid iow		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation							1	0d. Inside City Limits	-
sa-f sh tiffed	ctor	Maryland Baltimo	ore County	Tows	on									1 □ Yes 2 No	
23a or 28 Lst be no	Funeral Director	10e. Street and Number 520 Hampton Lane				10f. Zip 212	Code 286					ted S	/hat Coun State	25	
permit. Pages 1 and 2 should be filed within 7.2 hours after dearn with the warylan bearing the fleating and Mental Hygiene. Important: If fleat 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2√2 N If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1 □ Yes		ispanic (in, Mexic Speci		ecify Yes or N Rican, etc.)	No-	Black	- Americ k, White, Whi	etc.	
"natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usua kind of wo	d Occupa	ation during m	ost of work	ing	16b. K	ind of Bu	siness/Ind	lustry	
within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Home 1						Own	n Hor	ne		
other other vent, 1	BeC	17. Father's Name (First, Middle, Last)							e (First, Mida					
Menta Menta rarked	To	George Hulbert								izabet					
and z sn ealth and m 27 is m her traum		19a. Informant's Name/Relationship (Carol Schmitt (Da			229	Reyno	olds	Mil	l Roa		k , 1	Penns	sylva	nia 17403	
rages 1 tment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	fy)	Evan	ce of Dispo netery, cren IS Fur	neral	Chap	pel	Apri. 200	Date 1 20 , 07			City or To	Maryland	
Depar Impor any In once.		21. Signature of Funeral Service Lice	Lehm		Pe		ıl Ai	lter	nativ	es Fur				on Ctr.,P.A	٠ د
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mod	e of dyin	g, such	as cardiac	or respiratory	arrest,	Lauu	2103	Approximate Interval Between	
hysician		Immediate Cause (Final disease or condition resulting in death)	a. PANCREA											Onset and Death	
/Medical Examiner		resulting in dealin)	Due to (or as	a consequer	nce of):										
ured Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequer	nce of):										
tincate be executed g physician and as the burial-transit		resulting in death) Last	r as a consequence of):												
rimcare ng phy as the	/edical	IEEEWALE.	- V												
The law requires that the death cer te has been signed by the attendin bage 2 should be detached for use	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal d	eath 3	∃Ectopic pi ∃Other <i>(s</i> p		′			-	23d. Date Mor	e of delive	ery Day Year	
s that t ned by e detak	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	nderlying o	ause giv	en in Pa	rt I.	23e. Di	d tobacco	use contr	ribute to th	ne cause of death?	Ī
equire en sig ould b	ted b									1[∐Yes 2	No	3 Prob	ably 4x Unknown	
The lar	Completed									24a. Wali au pe 1∐ Yes	topsy rformed?	p	Were auto prior to co death? I∐Yes	psy findings available mpletion of cause of 2 No	
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			th (Check onl					
Phys er this eral dir	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 2	R/Outpatier 8b. Time o		28c. Injur Wor	4	Nursing He	ome 5 ☐ Re 28d. Describ				HOSPICE	_
nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Dag	y Year)	Injury	М		k? Yes 2	□No						
al or Atte s after des il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			e, farm, str	eet, factor	/, office				n (Street a Town, Stai		er or Rura	al Route Number,	
To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 v.	Medical (hysician: To the best miner: On the basis o and manner sta	f examinatio											
withi Com	Ž	29b. Signature and title of certifier				29	. Licens	e numbe	72.1		29d. Da		(Month,	Day, Year)	
7		30. Name and address of person who). '	TIMO	NIUM.	MD 21	.093				
Sta Regist		31. Date filed (Month, Day, Year) APR 2 0	32. Restr	ar's Signatu	re										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) - ^{Day} 2007 April 16, EILEEN ANN SLAUGHTER 5.5 AM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Essex Riverview Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) July 31, 1929 Months Days Hours 216-24-9407 1 □ M 2 💢 F Maryland 77 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Baltimore Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 2722 Burridge Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth R. Bond 17. Father's Name (First, Middle, Last) Joseph A. Staylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 Burridge Road-Baltimore, Maryland 19a. Informant's Name/Relationship (Type. Print) Elmer J. Slaughter-spouse 20h Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,MD 21234 Approximate Interval Between Onset and Death UU - (UVU) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) takon Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 2 **2** No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√0 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items: any Injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

Director

Funeral

à

Completed

Be

2

death with the Maryland

/Medical

and attending physician use for 1

The law requires that the death certificate be executed

or Attending Physician:

Hospital

death.

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be Certification: To

the this ieral Director: After th filled in by the funeral after death Medical

within 24 hours at To the Funeral E completely filled i the State Registrar

28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print) 70 9 · BASTERN BLVD ,

WASERM

MID

31. Date filed (Month, Day, Year) APR 2 0 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OKES 200 APRIL /Medical 4d. County of Death acility Name (If not institution, give Examiner Wh 7. Age (In yrs. last **Funeral** Months 1**X** M 2□ F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Armed F Black, White, etc. 2 □ No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Brother) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41410 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 JOGINDER P MEHTA HUSPITAL RANDAUS TOWN MO MORTHWEST CENTER

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

	1	For State Registrar	State of Mar		artment of H rtificate of L			iene _{eg. No.} 200	7 12766
		. Decedent's Name (First, Middle, Las	<i>t</i>)			1	2. Date of Dea	th	3. Time of Death
Physicia: /Medica		Mary Carolyn Saur	born				Month April	Day Yea 2007	
Examine		a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	-	4c. County of De	eath
	V	FutureCare Canton			Baltin			N/A	
Funeral		. Social Security Number 6. Se	□M 2□F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
Director	-	236-70-7675 Usual Residence of Decedent		110.			June 30), 1945 W	West Virginia
ow at		0a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
Many a-f sh ffied	2	Maryland Balti	more	Dundalk					1 □Yes ¾XNo
or 283		0e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?
23a ust b	Funeral Director	1947 Codd Avenue			21222			United St	
tems ter m	nue	1. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
s affe	DY I	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖺 No	Specify:		Specify: Wh	nite
2-UUSO 72 hours af natural", or	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	1	16b. Kind of Busines	
U 7 in 72 in 72 in Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done on the contract of the contr	during most of work d)	ing		
d with giene sr tha	Ę.	Elementary/0000mary (0 12)	+2	Barn	maid			Food and	Beverage
aryiand Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Re	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)	
Via Ould to Mentarked	0	Joe Cavrich				Lillie O			
Mar d 2 sh th and th and traum traum		19a. Informant's Name/Relationship (7						r, City or Town, State	
DESILITIOTE, INIGIT/JIBING ZIZID-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	Frederick D. Saur 20a. Method of Disposition	born, Sr. (20b. Place of Dispo-	sition (Name of	i i	Dunda Date	lk, Maryla 20c. Location - City	and 21222 or Town, State
ages nt of r: if it		1 Burial 2 ☐ Cremation 3 ☐			matory or other plac		2007	D-11-1	
Saltimor Permit. Pages Department of mportant: If it any Injury or one.	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Oak Lawn	Name and Addres	4/20/ ss of Facility			e, Maryland
Dep Dep any any any		1 OSEN PROS	2					Dundalk, 1 Marvland	
4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused th	e death. Do not ent					Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	^ /	OCACI	nona	Lune	,		Onset and Death
/Medical		resulting in death)	a. Due to (or as a c			/			
Examiner		Sequentially list conditions,	b						
ed sit	E L	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentified Cause (Disease or injury that initiated events	Due to (or as a d	consequence of):					
and and all-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):					
	dical		d						
ifficate g phy as the	edic								
death certifi e attending of for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2		⊒Ectopic pregnancy	,		23d. Date of	
death death	SICIS	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tir		Other (specify)	<u>'</u>		Month	Day Year
w requires that the death certific been signed by the attending should be detached for use as	Physician/Me	9 Unknown					00- 00-	h	e to the cause of death?
ords, Frequires that	ρ	Part II. Other significant conditions o	ontributing to death but	not resulting in the u	inderlying cause giv	en in Part I.			Probably 4 Unknown
ecord law requir as been si 2 should t	ed		<u> </u>						
The law ate has be page 2 sh	Completed						24a. Was a autop	an 246. Were prior med? death	autopsy findings available to completion of cause of
VITAI HEC sician: The law certificate has b irector, page 2 s		25. Was case referred to edical				00 Di(D	1□ Yes	2 No 1 Y	′es 2□No
on or vital ding Physician: T After this certificat funeral director, pr	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 10 Nursing Ho		ne) lence 6 □Other (S	(nacify)
g Phy g Phy er this	- 1	27. Manny of Death	28a. Date of Injury	28b. Time o				ow injury occurred	респу)
VISION Attending r death. ector: After by the fune	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		rear) Injury		Yes 2 □ No			
DIVISION I or Attending after death. I Director: After d in by the func	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	r - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or In, State)	Rural Route Number,
italo ral Di led in									
Hosp 4 hou Fune tefy fil	ca	(Check only 2 Medical Exar	ysician: To the best of miner: On the basis of e	xamination and/or in	nvestigation, in my o	opinion, death occur	rred at the time,		
To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	Medical	one) 29b. Signature and title of certifier	and mapper state		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
₹ 3 ₹ 8		1/8/1/1/	100		1	(877		2011	6 2007
	-	30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type.	Print)	,0/2	- 1	pry	
5			0 283	ath (Item 23a) (Type, Sm, s Signature	In Are	e Suite	203	21	209
Stat		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	had a	•			•
Registra	ır	APR 2 0	2007	w so so					

07-02839

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

losette Smith	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.												
	R	egistrar Decedent's Name (Fi	ant Baidella I	t\	Cert	ilicate of t	Jeani —		2. Date of Deat	g. No.	3. Time of Death			
Physician Medical Examine	**	7	_	ası)		514	111		Month April 14, 2	Day Year	0035 hrs			
Medical Examine		JOSEZ la. Facility Name (if not		rive street and nu	ımber)	140	. City. Town. or	Location of Deat		4c. County of Dea	ath			
\$		Bon Secours H		,			Baltimore			N	IA			
Funeral		5. Social Security Numb	oer 6.	Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Yea	r If Under 24Hr	s. 8. Date of Bin		Birthplace (State or			
Director		111 01 11		M 2 _X F	.=	88 Yrs.	Months Day	s Hours Mi	MARCH 16, 1968 Country) Md.					
	2	Jsual Residence of Dec	70.			0			7 / / / / / / / / / / / / / / / / / / /					
any.	_		County		10c. City,	Town or Location	1				10d. Inside City Limits			
bow id	_	Md.	N	IA		BALTI	MORE	=			1 Yes 2 No			
arylar 8a-f s at on	탏	0e. Street and Number				T	10f. Zip Code		10	g. Citizen of What Co	ountry?			
he M	uneral Director	111 1/	6/2	NTON	51.		á	1224	′	11.5	· A.			
with 1 18 23s	<u>e</u>	11. Marital Status	07	12. Was Dec	cedent Ever in U.S	6. 13. Was	Decedent of His	spanic Origin? (§	Specify Yes or No-	14. Race - Am	erican Indian, Black,			
leath r item	nue	1 X Never Married	2 Marr	ed Armed F	orces?	If Yes	s, specify Cubar	n, Mexican, Puert	o Rican, etc.)	White, etc.				
ufter o	o F	3 Widowed	4 Divord	ed If Yes, Give Yes		1 `	es 2 X No	specify:		Specify:				
ours a		15. Decedent's Educa	tion (Specify					tion (Give kind of e. DO NOT use re		16b. Kind of Busines	s/Industry			
6 72 h	<u> </u>	Elementary/Seconda		College (1-4 or 5+)		LABO		,	7.40	ustey			
within within Medi	Completed	127		1	1/4		ZHOU		ne (First, Middle, M	_				
Hyginel A		17. Father's Name (Firs								Robl	40.10			
21215-0036 Juld be filed within 7 Mental Hygiene. e event, the Medica	8		KNO		_	10h Mailing	Addrong (Ctro			nber, City or Town, Sta				
O sh B sh E .	- A	19a. Informant's Name/			16deca									
e, MD 1 and 2 shc Health and Fitem 27 is		Jave/le 20a. Method of Disposi		y/au	20b F	lace of Disposit	on (Name of ce	emetery.	Date	0., Md. 20c. Location - City	or Town, State			
altimore, M mit Pages I and 2 spartnent of Health pportant: If item 2 jury or other traur		1 X Burial 2		3 Removal f		romatory or othe	r nlace)							
imor Pages nent of iant: If or othe		4 Donation 5			N	11 CM	REMCL	Cem 4	121/01	MUNdal	e, ma.			
Baltimo permit Pag Department Important: injury or ot		21. Signature of Funera	al Service Lie	ensee	1	22. Na	me and Addres	s of Facility	EVERLY	D. Croma	t, Md. Tu 715 d. 2123			
a 50 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Jun,	he C	romi	uu	71	oo ear	ronet sow	Ave - /	salto, me	Approximate Interval			
Physician	K	23a. Part I. Enter the di failure. List only o	sease, or co ne cause or	mplications that one cach line.	caused the death.	Do not enter the	mode of dying	, such as cardiac	or respiratory and	est, shock, or heart	Between Onset and Death			
/Medical Examiner		Immediate Cause (Fina			one intoxi						Death			
4	1	or condition resulting in	n death)	Due to (or as	a consequence of):								
3.	۱,	Sequentially list conditi if any, leading to imme-		Due to (or as	a consequence of	·):								
	Examiner	cause. Enter Underlyin	ng Cause	С.										
1 - =	xal	events resulting in dea		Due to (or as	a consequence of):								
				d		<u> </u>								
be externation	dical	X UNPENDED		AMENDED,	27,28a-f,	perME, g8	68 <u>, 6/1/0</u>)7 T						
Box 68760, e death certificate be extending physician red for use at the burial		IF FEMALE: 23b. Was decedent pre-	gnant in the	23c. If yes,	outcome of pregi	nancy		Ectopic preg	nancy	23d. Date of deliv	ery Day Year			
68 certif nding	Įą.	past 12 months?	9.1-1.1	1 Live	nant at time of de	- 4-	er (Specify)	coopic preg	ilalicy	World	Duy			
Sox leath e atte for u	Sic	1 Yes 2 No 9	Unkn	own 9 Unkr	nown	J Oth	er (Opecity)			ì				
ords, P.O. Bo. w requires that the deat is been signed by the att should be detached for	ᇍ	Part II. Other significa	nt conditio	ns contributing	to death but not re	sulting in the ur	derlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
P.C	<u></u>								1 Ye	s 2 🗸 No 3 🗌 P	robably 4 Unknown			
ds, equir een si	ompleted	11		-					24a. Was		autopsy findings available to completion of cause of			
COF law r has b	힘									rmed? death	?			
tal Records tian: The law requ certificate has been ector, page 2 should	OI-						00 DI-	ce of Death (Chec	1 Yes	2 No 1 🗸	Yes 2 No			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rafter death. The law requires that the all Director. After this certificate has been signed by the funeral director, page 2 should be detacled in by the funeral director.	Be	25. Was case referred examiner?	to medical	Hospital:	Inpatient 2	FR/Outpationt		Tother -	sing Home 5	Residence 6 Ot	her:			
of Vi	유	1 ✓ Yes 2 27. Manner of Death	No			28b. Time of Ir		ury at Work?		how injury occurred				
n of V	ᇹ	1 Natural 5	Pendir		e of Injury th, Day,Year)	_	' ' '	Yes 2 X No	unk	, ,				
Sior Attend r death. ector: by the	Certification:	2 Accident	Investi	nation FIIU	4/14/2007 ice of Injury - At h	unk				Street and Number or	Rural Route Number, City			
Divis	Ě۱		X Could determ	not be	TT		, ractory, omco	bananig, oto	or Town,	State)	Baltimore, MD			
Spita bours meral		4 Homicide 29a. Certifier		14,44	<u></u>		ad at the time	data and place a		se(s) and manner as s				
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	<u>8</u>	(Check only one) 2 Me	ranying Phy edical Exam	iner: On the basis	s of examination a	ge, ueam occurr nd/or investigati	on, in my opinic	on, death occurre	d at the time, date	and place, and due to	the cause(s)			
To t To t	Medi	29th Signature and title		and manner	stated			nse number		29d. Date signed (
			- 1	(1/ 0	0			M.E.		April 14, 2007				
		Maryone	0 0	- you	X	.00-1			<u>.</u>					
8		30. Name and address Margarita Kore			use of death (Item edical Examir		nn Street I	Baltimore, Mi	21201					
		_		32. F	-									
Sta Registr	ite	31. Date filed (Month)	R 2 0	2007	gratiar a orginati	K L	1							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** XPRIL. 18, 2007 8:45 P ROBERT SANDS TEAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 8. Date of Birth Sept. Day, Year) 1,1963 Birthplace (State or Foreign Country) 6. Sex 1X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 218-74-2689 Yrs. Maryland Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location in then "naturel", or Iteme 23s or 28s-f show MD Baltimore Baltimore 1 Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9408 Windpine Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (ZNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Highway Elementary/Secondary (0-12) College (1-4or 5+) Highway Technican Administration 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Robert Gilmore Teal Eileen Lorraine Lucas ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Teal-spouse 9408 Windpine Road-Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H important: If ite eny injury or ott Moreland Memorial
Park Apr.23,2007 Parkville, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL Parkville, MD 21234 15 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiration **Physician** /Medical Due to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete Hospital or Attending Physician: : After this certification, 25. Was case referred to medical Be 26. Place of Death Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 XNo 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural within 24 hours atter uses...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier (tem 23a) (Type, Print) Registrar's Signature. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar			Certifica	te of Dea	ath		Reg. No. 20	07	12	169
Н			1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of i	Death
福	Physicia /Medic			Charles	Calv	in T	ucker,	Jr		14 20		5;47	рм
	Examin	_	4a. Facility Name (If not institution, giv	e street and number)		4b. City	, Town, or Loca	ation of Death		4c. County	of Death		
, <u> </u>				Fall Way			rkvill			Bal			
	Funeral Director		214-30-04/0	Sex 7. Age (h	n yrs. last birtl	rs. Months	er 1 Year If U	ours Min.	8. Date of Bir (Month, Date 10-27	1952	9. Birthp Cour	lace (State or ltry) VA	_
	pur »		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town	or Location						0d. Inside Cit	y Limits
	shov shov	5			•							1 🗌 Yes	
	the M	ect	MD Bal 10e. Street and Number	10	Parkvi		ip Code			10g. Citizen of	What Cou		
	a or	Funeral Director	9517 Hickory F	all Wav		101.2	21236	5		US		,	
	eath	era	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec			ecify Yes or No Rican, etc.)	- 14. Rad	ce - Americ		
936	be filed within 72 hours after death with the Maryland and Hyglene. do dither than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, sp		exican, Puerto ec <i>ify:</i>	Rican, etc.)	Specif	ck, White, ^{ty:} B 1	etc. .ack	
Maryland 21215-003	2 hou	Completed	15. Decedent's E	ducation	16a.	Decedent's Us	ual Occupation	n a most of work	ina	16b. Kind of B		dustry	
215	filed within 72 Hygiene. other than "nal ent, the Medics	old I	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired)		nig	IS	G		
2	filed wil Hygien ther th	8		4 years	Pr	ocess	Engin			Bethle		Steel	
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last							, Maiden Surnar	ne)		
yla		은	Charles C. Tu					lugert		tcher			
<u>Jar</u>	S a s		19a. Informant's Name/Relationship (Beverly L. Tuc	**	I	J	ss (Street and I ckory			er, City or Town arkvil		,	236
a)	ss 1 and 20 Health item 27 other tr	. 3	20a. Method of Disposition			Disposition (N			Date I	20c. Location			
	8 5 5 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Speci</i>	Removal from State	cemeter	y, crematory of Hill	cother place) Cem	4-2	0-2007				o, ^{MD}
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	wane	ب	11		North		e Balt	ast o, M	D 212	02
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do n	ot enter the m	ode of dying, su	uch as cardiac	or respiratory a	rrest,		Approximate Interval Bety	ween
	Physician	1	Immediate Cause (Final disease or condition	CORONAR	-Y DR	TEFY I	DISENSE				- 1	Onset and D	realli
	/Medical		resulting in death)	Due to (or as a c	-								0.0
	Examiner		Sequentially list conditions	b. DIDBETE	s me					> YEAR	<u>U</u>		
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
79.	and tran-	хаш	that initiated events resulting in death) Last	c Due to (or as a c	onsequence o	nf)·							
60,	be exician			240 10 (01 43 4 0	onsoquenos	.,,.							
¢3,09∠89	ertificate be executed ing physician and e as the burial-transit	Medical		m d						· · · · · · · · · · · · · · · · · · ·	-		
×	ding se as		IF FEMALE:	23c. If yes, outcome pf	pregnancy					23d D	ate of deliv	erv	
Bo	atten for u	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tin	Fetal death	3 ☐Ectopic 5 ☐ Other (onth		rear .
o	the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown			7 /						
Division or Vital Records, P.	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying	cause given in	Part I.	23e. Did	tobacco use con	tribute to	he cause of d	eath?
g	quires 1 sign	d by	NYPERLITIOEM	A					1 🗆	Yes 2 No	3 ☐ Pro	bably 4 □L	Jnknown
<u>Ö</u>	w rec	Completed	ARRITU						24a. Was	an 24b.	Were aut	opsy findings a	available
æ	he la e has age 2	ᇍ	- GBCSTT	-						ormoled?	death?		ause of
ta	ifficati or, pe		25. Was case referred to medical				26	Place of Dea	1 Yes	2No	1 🗆 Yes	2□ No	
>	/sicia s cert	o Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 [ER/Out	tpatient 3 🗍 I	Othor	4 ☐ Nursing H		idence 6 □Ot	her (Spec	fv)	
0	g Phy er thi	⊢	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. T	Time of	28c. Injury at Work?			how injury occu		· · · · · · · · · · · · · · · · · · ·	
0	nding th. r: Afte e fun	Ę	1 Natural 5 □ Pending 2 □ Accident investigation	, , , ,	ear) II	njury M		2□No					
VIS	Atte	100	3 ☐ Suicide 6 ☐ Could not be determined		- At home, fai	rm, street, fact	ory, office		28f. Location	Street and Num	ber or Rui	al Route Num	ber,
	al or s afte al Dir	Certification:	T I I I I I I I I I I I I I I I I I I I	building, etc. (opeony)					www.ctatoy			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (hysician: To the best of a miner: On the basis of ex	xamination an								s)
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner state	u.		9c. License nu	mber		29d. Date sign	ed (Month	Day, Year)	
	N N N		1 CO maluna	300 m			031	15110		01/	//	777	
7			On Name and address of a second	7 17	th (Itom 00=) (Type Print	D 3	1247			-/_	7 /	72/
	Le		30. Name and address of person who	ZN TNC, M	0	Type, Print)	1349	Rol.	Rin R	d Ba	1to	m)	406
	Sta	ate	31. Date filed (Month, Day, Year)	32. Ogistrar's		-0-		246	.//`	~4	100	TW.	

Registrar

APR 2 0 2007 Brew & Goods

			For State	State of N	Marylar		artment of				20	07	12770
	Physici	an	1. Decedent's Name (First, Middle, L	9				TE		2. Date of Dea	Day	Year	3. Time of Death 4:45-7M
1	/Medio		4a. Facility Name (If not institution, gi		er)		4b. City, Town,		of Death	49×12	4c. County	of Death	9.73/1
			BON SECOURS BALT 5. Social Security Number 6.			YSTEM last birthday)	BALTI If Under 1 Yea		24 Hrs.	8. Date of Birt	th	9 Rirthol	ace (State or Foreign
	Funeral Director			1 M 2 X F	84	Yrs.	Months Day		Min.	(Month, Da	y, Year)	Count	mp)
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10	Od. Inside City Limits
	Maryl -f sho fled at	tor	MD			BALTIN	ORE.						1. Yes 2 □ No
	in the	Director	10e. Street and Number			DIMILI	10f. Zip Code	1			10g. Citizen of	What Count	try?
	ath wil		1903 RIGGS AVENU					217			USA		
336	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Deceder Armed Force 1 Tyes 20 If Yes, Give Year or Dates	s? X .No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗷 N			ecify Yes or No Rican, etc.)		ce - America ck, White, e	
5-0036	72 hou natura ilcal E	sted	15. Decedent's E				dent's Usual Occ kind of work don		et of worki	00	16b. Kind of B		
2	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT use retii	red)		ny	HEA	T 1773	
2	filed v Hygie Ither t		17. Father's Name (First, Middle, Las	st)		PIEI	JICAL AS			(First, Middle,	Maiden Surnar		
an	should be and Mental marked o matic eve	To Be	WILL CARTER	,						ARTER		,	
Maryland	d 2 shou th and N 7 is mar traumat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stree	et and Numb	er or Rura	al Route Numb	er, City or Town	State, Zip	Code)
	s 1 and 2 f Health item 27 i		CHARLES R.CARTER	/SON	1		RIGGS				MARYLAN		217
altimore,	00-2		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3		16		osition (Name of matory or other p			Date	20c. Location		
I	permit, Pag Department Important: I any Injury c		4 □Donation 5 □ Other (Spec		M		REMATORY 2. Name and Add			-2007			MARYLAND
Ra	Department any any		Cime of a	ma	to	-	701–31		JA		MUKTUN		S F.H.,INC 1217
500	Physician		23a. P. Enter the disease, or consider K, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ine. ドミC	th. Do not ent		ying, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner bhysician and the burial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consec	/ N の N juence of):	14 0) -EROT						N KNEWAN
Box 6	death certifi e attending d for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	1 2 ☐ Feta t at time of o	al death 3	⊒Ectopic pregnar ⊒ Other <i>(specify)</i>				- 1	ite of delive	ry Day Year
Ų,	es tha gned t	by P	Part II. Other significant conditions	4	but not res	ulting in the u	nderlying cause (given in Part	1.				e cause of death?
ora	w require been sig should b	ted	DEHYDRA' CACH EX	11010			A7			10	Yes 2□No	3 Prob	ably 4 ⊡Onknown
Vital Records,	The la		HYPERT		N					24a. Was autor perfo 1∐ Yes	ormed?/-	Were autop prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of
<u> </u>	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Dinpa	O.T.	1500-1-1				Check only o			
0	g Phys er this eral dir	n: To	27. Manner of Death	28a. Date of I	niurv	28b. Time o	f 28c. In	jury at	ursing Ho	me 5 L Resi 28d. Describe I	dence 6 Ott	ner <i>(Specify</i> rred)
Division or	To the Hospital or Attending Physician: and the Euneral Director: After this certifica completely filled in by the funeral director, t	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of	Day Year) injury - At h	Injury ome, farm, str		Yes 2		28f. Location (Street and Num	ber or Rura	Route Number,
בֿ	pital or vurs afte eral Dir filled in						h agained at the	time data a		City or Tou			
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exa	Physician: To the be aminer: On the basis and manner	s of examina	ation and/or in	n occurred at the	y opinion, de	ath occur	red at the time,	date and place	anner as st and due to	ated. the cause(s)
	Veith To 1	Σ	29b. Signature and title of certifier	Sullow	Lns	ο.		nse number 233	00		29d. Date signed APP 12		
			30. Name and address of person who	completed cause of	of death (Iter	n 23a) (Type,	Print) 130 V / 13A 2	N 3	Edd ST,	MRS BA	12051 210 M	λ.	21223
	Sta	to	31. Date filed (Month, Day, Year)		strar's Sign					-5.011			

Registrar



ORIGINAL

07-02998

Christopher Wayma		State of Maryland / Department of Health and Mental Hy For State Certificate of Death	/giene	200	17 127
Physician/	R	For State egistrar Decedent's Name (First, Middle,Last) Certificate of Death	Reg. 2. Date of Death	. No.	3. Time of Death
Physician/ Medical Examiner		Christopher Wayman	Month E April 19, 20		0039 hrs
<u>{</u>	4	a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth	Foreig	
Director	2	2/3 - 06 - 5395 1 X M 2 F 23 Yrs. William Sual Residence of Decedent	UCT.d.	<u>3,1983 _~</u>	untry) IVIA.
any	-	Da. State 10b. County 1 10c. City, Town or Location			10d. Inside City Limits
* .l	Ĺ	Md. NA Baltimore	140	Oiline and Mile of Court	1 Yes 2 No
the Maryland a or 28a-f sh tified at once		0e. Street and Number 10f. Zip Code 2/2/4	109	g. Citizen of What Cour) }
215-0036 be filed within 72 hours after death with the Maryland antal Hygiene. Red other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once. Be Completed by Funeral Director		1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14, Race - Ameri White, etc.	can Indian, Black,
ter deat ", or ite		1 Yes 2 No No specify:		Specify: B	Ack
ours aft atural' xamine	î -	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired.)		16b. Kind of Business/I	ndustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. frant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner To Be Completed by I		Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechania	C	Solf-F	molnied
215-0036 be filed within 7 had Hygiene. rked other than ent, the Medica Be Comple	1	7. Father's Name (First, Middle, Last)	(First, Middle, Ma	aiden Surname)	ripioyea
2121 2121 Mental F Marked Cevent, I		David Samuel Wayman Beat 9a, Informant's Name/Relationship (Type, Print) 100 er) 19b. Mailing Address (Street and Number or F	rice Bural Boute Numb	Griff	Zin Code)
MD 21 d 2 should th and Me n 27 is ma numatic ev	1	Mrs Beatrice White 11715 N. Ashburt	on St.	Balto. N	11,21216
re, MC s Land 2 s of Health at If item 27		0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2	1 1	20c. Location - City or	Town, State
Baltimore, bernit, Pages I ar Department of He important: If ite	L	Donation 5 Other Specify: Woodlawn Cemetery 17	5/2007	Balto.	Md.
Baltimo permit. Pag Department Important: injury or ot	2	1 Squature of Funeral Service Ligensee	uneral	Home, P. 1	}.
Physician	12	3a/Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of Jailure, List only one cause on each line.	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical taminer	1	mmediate Cause (Final disease a. Multiple Gunshot Wounds			Death
		Due to (or as a consequence of): Sequentially list conditions, b.			
niner		f any, leading to immediate Due to (or as a consequence of):			
couted and transit	3	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execul an and al - tra		UNPENDED AMENDED			
	I 2	F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of deliver	y Day Year
Division of Vital Records, P.O. Box 6876 the Hospital or Attending Physician: The law requires that the death certificate him 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phy oppletely filled in by the funeral director, page 2 should be detached for use as the User of Certification: To Be Completed by Physician/Miscal Certification:		past 12 months? 4 Pregnant at time of death 5 Other (Specify)		I World	Suy . Ou.
b. Box (the death of the attended for use		Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
P.O. res that the signed by be detacl	2		1 Yes	2 No 3 Pro	bably 4 Unknown
Records, The law require. ficate has been sig. page 2 should be Completed	200		24a. Was a autops	y prior to	utopsy findings available completion of cause of
Recc The la icate ha			perform 1 V Yes 2		es 2 No
ital Recition: The scerificate rector, page	3 2	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 ✓ DOA Other; 4 Nursing the second of the se		Residence 6 Othe	er:
n of Vital Records, ling Physician: The law requir After this certificate has been sifuneral director, page 2 should ton: To Be Completed	- 17	17. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe h	ow injury occurred	··
ision Attendin r death rector: A by the fu		1 Natural 5 Pending Apr 19, 2007 ar 0012 hrs 1 Yes 2 No	Subject shot		
Division o spital or Attending tours after death neral Director: Aft filled in by the fume Certification:		3 Suicide 6 Could not be determined (Specify) Sidewalk and Grass	or Town, St		ural Route Number, City
Divisior To the Hospital or Attent within 24 hours after death To the Finneral Director: completely filled in by the	- 1 2	19a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as sta	ted.
To the Ho within 24 To the Fr completel		Creek only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	and place, and due to the signed (Mo	
A	• •	29b. Signature and title of certifier 29c. License number O.C.M.E.		April 19, 2007	nni, Day, 1 6ai/
X	-	30. Name and address of person who completed cause of death (Item 23a)			
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 21201	· · · · · · · · · · · · · · · · · · ·	
State Registra	-	B1. Date filed (Month, Day, Year) APR 2. 0. 2007			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month A 1/21L WHITTICO **Physician** HILIP 16-10pm 2007 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Randallstown
er 1 Year | If Under 24 Hrs. | 8 Baltimore Northwest Hospital 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min Director 216-03-7890 90 22 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 No Director MD Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Me Ital Examiner must be reany Injury or other traumatic event, the Me Ital Examiner must be reany Injury or other traumatic event, the Me Ital Examiner must be reany Injury or other traumatic event, the Me Ital Examiner must be reany Injury or other traumatic event, the Me Ital Examiner must be reany Injury In Funeral 3 Autumn Blaze Ct. 21163 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black Specify 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Merchant Seaman U.S. Coast Guard na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be to nent of Health and Mental 2 Frank W. Whittico Louisa Whittico 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Autumn Blaze Ct, Woodstock, Md 21163
Disposition (Name of Date 20c, Location - City or Town, State Irvina Mallory-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Garrison Forest Vet 4/20/07 owings Mills, MD 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licen ie 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical Due to ker as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 124a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2L2No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: 4
filled in by the fi death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 054288

30. Name and address of person who completed cruse of death (Item 23a) (Type, Print) Northwest Instituted Course

3+1

State 31. Date filed (Month, Day, Year)
Registrar

PR 2 0 2007 Beren Is food

A. WILLIAMS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Time of Death Physician/ Month Day April 13, 2007 Williams 1637 hrs ¶odical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Fort Washington Medical Center Fort Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director Country) 78-84-239 1 4M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 LNO 23a or 28a-f show notified at once Accokeek be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 1550 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married to rich Health and Mental Hygiene
t. If item 27 is marked other than "natural", or iten
other traumatic event, the Medical Examiner must Yes American Yes 2 No specify 4 Divorced If Yes, Give Year ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SELF Laboner 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Millner ernice Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 should ဥ Helen Road MD 20607 Millner Accokeek mother Bernice 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 21/07 Lincoln Memorial 4 Donation 5 Other Specify Sewice, P.A. 21. Signature of Fune at Ser ice Lice 22. Name and Address of Facility
Han Profitse
5/26 Belan Roac Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last be executed and Physician/Medical Y UNPENDED attending physician or use as the burial -^{AM}#233,27,perME, g868, 6/15/07 TI 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Ö Š 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? this certificate has 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Division 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined 24 hours a Funeral 1 4 Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

Margarita Korell MD. 31. Date filed (Month, Day, Year)

Monte

29b. Signature and title of certifier

2. Registrar's Signature

and manner stated.

30. Name and a dress of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

April 14, 2007

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2007

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1 Decedent's Name (First, Middle, Last) 8:50 AM **Physician** 2007 Rosa Yancey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimul Sinai HospHal N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□M 2□¥ Mar 16, 1919 Virginia Director 88 214-24-9273 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Xes 2 ☐ No Baltimore N/A Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21213 1300 East Lanvale Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland 2121 College (1-4or 5+) Own Home Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental Queen Jennings Ed Yancey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2916 Ulman Road Baltimore, Maryland 21215 Lillian Williams Daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Bivirial 2 □ Cremation 3 □ Removal from State 04/20/07 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Incens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardint Acute 12 45 /Medical Due to (or as a consequence of): 12 hrs Examiner Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760. aftending physician Physician/Medical IF FEMALE: nse 9 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 mont Month for 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform Denenta 2 No 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Iniury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Parkent

State Registrar

Name and address of person who completed

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4:30 pm April 2, 2007 Winifred F. Aufricht /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F June 10, 1926 England 80 Director 380-30-0485 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at South 1 ☐ Yes 2 No Director Bluffton Carolina Beaufort 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral #10 Devant Drive East 29909 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: ģ 3 Nidowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold William Fell Jessie Nowell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Heyse - Daughter 307 Warrenton Drive, Silver Spring, Maryland 20904 Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/2007 Brentwood, Maryland Ft. Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1☐ Yes 2 4NO To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 LNO 1 [Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

31. Date filed (Month, Day, Year) APR 04 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Cenyly.

29c. License number

0057630

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Man		epartme <i>Certifica</i>			Mental H	ygien Reg. N	4001	16	2778
	Physic /Medi		1. Decedent's Name (First, Middle, L. Roy Rog	er Adams					2. Date of D	Death	ay Year		e of Death
	Examir Funeral Director	ner	217-14-8976	MORIAL H	OSPITA In yrs. last birth 89 Yi	LE	ASTC er 1 Year	f Under 24 Hrs. Hours Min.		lirth Day, Year	c. County of Dea I A L 9. Bir 7978 De	BOT	ate or Foreign
Aclams Reig Baltimore, Maryland 21215-0836	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, it a Medical Examinar must be notified at once.	To Be Completed by Funeral Director	19a. Informant's Name/Relationship Ruby Adams 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lices)	ine 12. Was Decedent Eve Armed Forces? 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes Give Year or Dates:	19b. N 19b. N 103 20b. Place of to commetery, Denton	13. Was Dec If Yes, sp. 1 Yes Decedent's Us Give kind of with the Do Not the Pre Mailing Addres B Deep December 12. Name 2. 2. Name 2. 12. Sc.	as (Street and Shone and Address of Fune Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and Address of Lath Security Shone and	Mother's Nam Minnie Number or Ru Road, 1 4/14 of Facility Lal Home	me (First, Middle Morris ral Route Number 1, 2007	Uni 16b. t 16b. t Col ber, City Mari 20c. L Der	Commence Commence Sumame)	puntry? Les of encan Indian e, etc. Leasia. Andustry Zip Code) 629 Town, State	n. n
68760,	Attending Physician: The law requires that the death certificate be executed to death. Additional to certificate has been signed by the ettending physician and position and the funeral director, page 2 should be deteched for use as the buriat-transit and the contract of the funeral director.	edical Examiner	23a. Part 1. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	de of dying, s	Hon	or respiratory	arrest,		Approxir Interval I	mate Between nd Death
	it the death certific by the ettending F teched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 Ectopic 5 Other (s					23d. Date of deli Month	ivery Day	Year
Division of Vital Records, P.O. Box	e law requires that the has been signed by ge 2 should be detec	Completed by Pr	Part II. Other significant conditions of	ontributing to death but no	ot resulting in th	he underlying	cause given i	n Part I.		Yes 2	24b. Were au	obably 4	Unknown
Vital R	sician: The certificate ha irector, page	Be	25. Was case referred to medical examiner?	Hospital: '\			0.11	3. Place of Deal	perf 1 Yes	ormed? 22 No one)	death?	2 No	ii cause oi
ision of	ttending Physical distribution of the funeral distribution	Certification: To	1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Ye		ne of ury M	28c. Injury at Work? 1 Yes	4 Nursing Ho	28d. Describe	how inju			
Div	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	cal Certif	4 Homicide determined 29a. Certifier (Check only 2 Madical Eval	building, etc. (S	Specify)	teath occurred	at the time	date and place,	City or To	wn, State) and manner ac	atatad	
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifie	niner: On the basis of exa and manner stated.	amination and/o		c. License nu	ımber	red at the time.		te signed (Monti		
			30. Name and address of person who Dennett So.	completed cause of death	(Item 23a) (Ty	rpe, Print)		n St	Fastn	4	-10 - 2	2160	7
	Sta Registra		31. Date filed (Month, Day, Year) APR 1 2. 2007	32. Registrar's		and s			C 310	1 1			

			For State of Maryland / D State Registrar		tment of H		ınd Mer	ntal Hygie Reg.	711117	12779	
3			Decedent's Name (First, Middle, Last)					Date of Death		3. Time of Death	
	Physici		Jessie Louise Andrews					Month Dry 1 4	Day Year	6'00a M	
Q.		Medical Vessile Louise Andrews 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea					f Death	1	4c. County of Dea		
	LAGIIIII	C1	253 E. Main St. Elkton						Cec	i 1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under 1 Year	If Under 24 Hrs. 8. Date of Bir			rth 9. Birthplace (State or Foreign		
	Director		264-36-1037 ¹□M 2XF 82 Y	Yrs.	Months Days	Hours	[™] Dec	ember	31,1924	FL.	
	D		Usual Residence of Decedent								
	nylan how Lat	_	10a. State 10b. County 10c. City, Town	or Loca	ation					10d. Inside City Limits	
	e Ma la-f s tiffiec	cto	MD Cecil E	1kt	on					17∏ Yes 2 No	
	iff th or 28	ire	10e. Street and Number		10f. Zip Code			10g.	Citizen of What Co	ountry?	
	th w 23a ust b	Funeral Director	253 E. Main St.		21921				U.S.	Α.	
	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cuba	spanic Orig	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, Whit		
36	afte or it		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 💸 ☐ No If Yes, Give	1[Yes 2 XNo	Specify:			Specify:	. n . l	
21215-0036	be filed within 72 hours after death with the Maryland tital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	D				100		White	
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	nt's Usual Occupa ind of work done d O NOT use retired:	lurina most	of working	160	o. Kind of Business	Industry	
12	vithir sne. than	E D	Elementary/Secondary (0-12) College (1-4or 5+)		memaker				Househ	014	
	Hygid Hygid Ither nt, th		17. Father's Name (First, Middle, Last)	110			r's Name (Fi	rst, Middle, Mai		Oid	
and	l be f ntal l ed ol	Be					,				
Ž	hould d Me nark natio	2	Vernon L. Vereen 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing				. Jone	ity or Town, State, a	Zin Coda)	
Maryland	d2s than 7isi		1		E. Main				, ,		
	1 an Heal em 2		20a. Method of Disposition 20b. Place of	Disposi	tion (Name of	1	Date		Location - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		1 LXBurial 2 LiCremation 3 LiRemoval from State	*	atorý or other place emeter y		ri1	7,2007	Elkto	·	
量	iit. Purtme		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Thisee							II, FID	
Ba	Departing any lonce		21. Ogradue of Falloria	An	Name and Addres drew G.						
ř	×		23a Part1 Enter the disease, or complications that caused the death. Do no	25	9 E. Ma	in S	cardiac or re	E1kton	, MD 21	Q 2 1 Approximate	
		55 2	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on Lach line.	N	201/2010	100	2000	A.		Interval Between	
	Physician /Medical		Immediate C the (Final disease or culdition resulting in disath)	11,	OHNY	2016	icy	<u> </u>		6uccis	
100	Examiner		Due o or as a correction of	Due to for as a, con-supply of):				Years			
7		F G	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):		100				1001.)	
	uted Insit	듩	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć,	ficate be executed physician and is the burial-transit	Examiner	resulting in death) Last Due to (or as a consequence o	of):							
8760,	e be sicia	dical									
89	ificat g phy as th	edi							0		
X	ndin use	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy						23d. Date of de	livery	
.O. Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year	
Ö	t the	hys	9 ☐ Unknown								
Records, P.	s than ned le det	by P	Part II. Other significant conditions contributing to death but not resulting in	the und	lerlying cause give	n in Part I.		23e. Did tobac	co use contribute to	the cause of death?	
Ö	quire en sig uld b	be be	LONE					1 🗆 Yes	2 No 3 □ P	robably 4 Unknown	
ပ္သ	s bee	lete	, , ,					24a. Was an	24b. Were a	utopsy findings available	
æ	The la	Completed					_	autopsy	d? death?	completion of cause of	
24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autoprior to cord death? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Was case referred to medical examiner? 1 Yes 2 No 25b. Residence 6 Other (Specify) 25b. Time of Injury at Work? 1 Yes 2 No 25b. Discribe how injury occurred work? 1 Yes 2 No 25b. Discribe how injury occurred work? 25b. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 26c. Place of Injury at Work? 27c. Injury at Work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work?							3 2 No				
>	Physician: r this certifica ral director, i	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	tpatient	3□ DOA Othe	ar.			e 6 □Other (Spe	ncify)	
0	ding Phys J. After this funeral di	Ë	27. Manner of Death 28a. Date of Injury 28b. T	ime of	28c. Injury Work			Describe how			
<u>ō</u>	Attending It death. ector; After by the fune	atio	1 Matural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation	ijui y		 ∕es 2 🗆 1	No				
<u> </u>	r Atte er de recto by th	ti li	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, stree	et, factory, office		28f.	Location (Stree City or Town, S		ural Route Number,	
Ö	talon saft alDi	Certification:									
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, (Check only Medical Examiner: On the basis of examination and	death	occurred at the timestigation, in my or	ne, date an	d place, and	due to the caus	se(s) and manner a	s stated.	
	the H iin 24 the F	Medical	and manner stated.								
	To the within To the Comple	2	29b. Signature and title of certified		29c. License	number		299	Date signed (Mont	th, Day, Year)	
			C HHIII WWWD		14	>/>	>	64	10117	200/	
	3		30. Name and address of person who completed cause of death (Item 23a) (7	Type, P	rint)						
	2		John Mulvey, MD								
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	asti.	,						
	Registr	ar	APR 9 2007 Heave 10.	The same							

			4 101	artment of Health and Me	ntal Hygier	18 007	12780
5				rtificate of Death	Reg. N	NO- UU /	12700
1	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
1	/Medic		Stephen Ralph Andrews, J 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	oril 7,	2007 4c. County of Death	8:00a [™]
1	Exami	lei	253 E. Main St.	E1kton		Cecil	
- C.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		. Date of Birth (Month, Day, Yea	9. Birtho	lace (State or Foreign
ķ.	Director		219–10–8731 ¹\\$\text{\$\}\$}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}			11,1915	MD
	land bw It		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	ocation		1	0d. Inside City Limits
	Mary a-f sh tied a	ţċ	MD Cecil Elkt	on			1 x Yes 2□No
	th the or 282 e noti	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	ntry?
	ath w		253 E. Main St.	21921		U.S.A.	
	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1★TYENES 2 □ No	Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
936	72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examiner must be notified at	þ		1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
0-0	72 hou natura ical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation be kind of work done during most of working	16b.	Kind of Business/Inc	dustry
2	ithin 7 ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
7	iled w Hygiei ther tl	S	12 8	Doctor 18. Mother's Name (F		edical	
and	d be f ental I ked of	To Be	Stephen Ralph Andrews, Sr.	Rosa Jo		on ourname)	
ary	shou and M s mar	-	•	ing Address (Street and Number or Rural F		y or Town, State, Zip	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Stephanie Darron/Daughter 253	E. MainSt., Elk	ton, MI	21921	
ore	ges t t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of paratory or other place) April	a	Location - City or To	
ij	t. Pag rtmen rtant: rjury			Cemetery 2007 2. Name and Address of Facility Andrew G. Gee Fu	, E1	lkton, M	D
Ba	permi Depa Impo any ir		21. Si hature of supple 1 service Licensee 2	Andrew G. Gee Fu	neral H	lome	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	259 E. Main St., ter the mode of dying, such as cardiac or r	Elktor espiratory arrest,	1, MD 2	1 0 2 1 Approximate
	Physician		snock, or heart failure. List only one cause on each line. Immediate Cause (Final	Α.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	3 01366			- 92015
ũ	Examiner	_	Sequentially list conditions, b. Arterio Scler	05,5			5 years
	ted nsit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
<u>,</u>	execui n and al-trai	Exan	that initiated events c				
8760,	cate be executed oblysician and the burial-transit	dical	d				
Ö	ng ph	Med	IF FEMALE:				
Box	The law recuires that the death certific tte has been signed by the attending p have 2 shou d be detached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [⊒Ectopic pregnancy		23d. Date of delive Month	ry Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 [Other (specify)			,
<u>. </u>	w requires that the deben signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?
Vital Records,	quires in sign	ed by			1 ☐ Yes	2 No 3 □ Prob	ably 4 □Unknown
000	e law re has bee	Completed			24a. Was an	24b. Were autor	psy findings available
		Som			autopsy performed? 1∐ Yes 2 🛣	death?	npletion of cause of
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)		
o	Phys r this ral dir	-T	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatiel 27. Manner of D ath 28a, Date of Injury 28b, Time of		Residence	6 □Other (Specify	/)
on	nding th. : Afte	tion	1 Statural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	1. Describe now in	jury occurred	
Division or	Atter er dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	reet, factory, office 28f	Location (Street City or Town, Sta	and Number or Rura	I Route Number,
۵	ital or rs afte ral Dia led in	Cert	building, etc. (executy)		City of Town, Ole	110)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	ica	29a. Certifier (Check only (Ch	th occurred at the time, date and place, and overtigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	o the ithin 2 o the o the complex	Medical	one) and manner stated. 29b. Signature and title of certifier ,	29c. License number	29d. D	Date signed (Month, i	Dav. Year)
	ک∓≼ۃ		Day only Course	0007463		4.9 - 67	y, ,
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
Ų	34/VA		30. Name and address of person who completed cause of death (Item 23a) (Type, Roll of All of	138 (athedral St.	2114	on Mo	21921
	Sta Registr		31. Date filed (Month, Day, Year) APR 9 2007 32. registrar's Signature	carle			
	negisti	aı .	0 2001				

KNOWN TO PHYSICIAN

NAME

JOHN

the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Funeral Director: filled in by To the Fun within 2

> State Registrar

SURESH SHANDELYA M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 32. Registrar's Signature

29c. License number

D52739

29d. Date signed (Month, Day, Year)

APRIL 5, 2007

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** Pearl Frey Brown 6:35 PM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital *Hagerstown* Washington If Under 1 Year If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 M 2 1 F 220-05-6505 97 Director June 14, 1909 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "naturel", or items 25a or 28a-f show ant: If item 27 is marked other than "mature" be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13213 Greensburg Road 21783 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No þ Specify 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packing House Orchard 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Elmer Frey Margaret C. Stouffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce E. Rivera (Daughter) 422 West Main St. Waynesboro, Pennsylvania 17268 20b. Place of Disposition (Name of cemetery, crematory or other place)
Welty's Church Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or of once. April 19. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Smithsburg, Maryland Cemetery 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner herusc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 40 1□ Yes Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 0 No 1 Hipatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Aatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after fo tre... within 24 hours arter To the Funeral Dir Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature

DHMH 17 Rev 1/2001

State

Registrar

30. Name and

31. Daye filed (Month, Day, Year)

20

2007

MO

address of person who completed cause of death (Item 23a) (Type, Print)

12511

			1 - For State Registrar	State of M	arylan	-	artment rtificate				iene _{eg. N6} - 0 0 7	12783		
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La. ROSE 4a. Facility Name (If not institution, give		3E K	ZMA		own, or Lo	ocation of Death	2. Date of Dea Month MAR CH	Day Year	7 9:05 TM		
	Funeral Director	lei	HEBREW HOME OF GE 5. Social Security Number 6. S	REATER WAS		FON last birthday) Yrs.	If Under 1	RO(CKVILLE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08 / 04 / 1	MON Year) 9. B	ITGOMERY irthplace (State or Foreign JOUNTY) VORK		
	the Maryland 28a-f show notified at	tor	10a. State 10b. County MARYLAND MONTGOME	RY		y, Town or Lo	ecation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	th with the 23a or 28a tal be not	al Director	10e. Street and Number 6121 MONTROSE ROAL		1		10f. Zip 0		0852	1	Og. Citizen of What C	Country?		
Division of Vital Records, P.O. Box 68760,	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. itam 27 ia marked othar than "natural", or itams 23a or 28a-1 shov other traumatic event, Tre Modicul Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:		1	Was Decede f Yes, specif	_	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.		
21215-0	filed within 72 h Hygiene. Athar than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5	i+)	(Give	DO NOT use	done duri	ing most of work	ing	16b. Kind of Busines			
Division of Vital Records, P.O. Box 68760, Pospital or Attanding Physician: The law requires that the death certificate be executed	2 should be filed within and Mental Hygiene. is marked othar than sumatic avant, T.e.M.	To Be C	17. Father's Name (First, Middle, Last) ELIJAH STARR					G	GWENDAL		Maiden Sumame)			
	es 1 and 2 sh of Health and f itam 27 ia m r other traum		19a. Informant's Name/Relationship (CERALD BERMAN, SO) 20a. Method of Disposition	N	20b. P		STRAI	ND DR	R #4, N.	BETHESI	, City or Town, State, OA MARYLA 20c. Location - City o	ND 20852		
Baltimo	Pag nent ant: I		2 ☐ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer	')		SINAI DA	CEME: Name and NZANSI	FERY Address of XY-GC	LDBÉRG	MEMORIAL	CHAPELS.	FLORIDA		
	Physician /Medical Examiner		23a. Part. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	P14	n. Do not ent	or the mode	of dying, s	LE PIKE	, ROCKVI or respiratory arre	LLF. MARY	Approximate Interval Between Onset and Death		
3760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as C. Due to (or as d.										
.O. Box 6	that the death certific led by the attending p detached for use as i	by Physician/Me	nysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pred Other (spec				23d. Date of de Month	elivery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions of SENILE	DEME	ut not resu	ulting in the ur	nderlying cau	ise given i	in Part I.	23e. Did tob	4/	to the cause of death? Probably 4 Unknown		
al Reco	The law ate has b page 2 sl	Completed								24a. Was ar autops perforn 1 Yes 2	prior to			
of Vita	g Phyaician: The this certificate eral director, pag	n; To Be	27. Manor of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur	y	ER/Outpatien 28b. Time of		Othor	4 Nursing Ho	n Check onl one me 5 ☐ Reside 28d. Describe ho	nce 6 □Other (Spe	ecify)		
lvislon	spital or Attanding Phous after death. Naral Director: After the filled in by the funeral	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	M 1 ☐ Yes 2 ☐ No							eet and Number or Rural Route Number, State)			
	4 4 4 9 4 9 4 9 4 9 4 9 4 9 4 9 4 9 4 9	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of iner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at estigation, in	the time,	date and place, on, death occurr	and due to the ca	use(s) and manner a ite and place, and du	s stated. e to the cause(s)		
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	Hola		M.D	29c. I	License nu	umber 3543	36	Od. Date signed (Mon HADCH 30	th, Day, Year) O, 200 7		
	V		30. Name and address of person who of BAROARA KALV	6119,6	121	HON	Print) TROSE	E RO,	AD, ROC.	KVILLE	, MD 2	0,2007		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 20	32 legistra	r's Signat	ure do	self)							

Dhunia.		1. Decedent's Name (First, Middle, Las	t)					2	2. Date of Dea Month		V	3. Time of Death			
Physicia /Medic		nai vaini bai Lui							April 2	Day 2, 2007	Year	6:45 a			
Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City, Tox	wn, or Location	of Death		4c. Coun	ty of Death				
		Renaissance Gardens-R	iderwood l	Nursing	Home	Si	lver Spri	ing		Мо	ntgome	ry			
Funeral		Social Security Number 6. Se	x 7 ⊒M 25x F	. Age (In yrs.	last birthday)	If Under 1 Y Months D	ear If Unde ays Hours	r 24 Hrs. 8 Min.	. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreigntry)			
ector		175-12-5173 Usual Residence of Decedent		86	Yrs.				May 7,		Peni	nsylvania			
if item 27 is marked other then "naturel" or items 23s or 28e-f show or other traumatic event, the Midical Examiner traus by notified at	tor	10a. State 10b. County Maryland Montgom	erv	100.01	ity, Town or Lo	Silver S	Spring					10d. Inside City Limit: 1 ☐ Yes 2 🗷 No			
De not	Director	10e. Street and Number				10f. Zip Co	·		1	0g. Citizen of	What Cour	ntry?			
THE STATE OF	ra	3160 Gracefield					20904			 ,	U.S.A.				
	- I	11. Marital Status	12. Was Deced	es?		Vas Decedent Yes, specify	of Hispanic Or Cuban, Mexica	rigin? (Speci In, Puerto Ri	fy Yes or No- can, etc.)		 Race - American Indian, Black, White, etc. 				
13000	by Funeral	1 Never Married 2 Married 3 St Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dat		1	□Yes 2【A	No Specify			Specify: Whi					
	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give i	ent's Usual O kind of work d OO NOT use re	one durina mo:	st of working		16b. Kind of I	Business/In	dustry			
	E O	Elementary/Secondary (0-12)	College (1-4	for 5+)		omemaker	•			0	wn Home				
ď	0	17. Father's Name (First, Middle, Last)				omemuice:		er's Name (First, Middle, F						
9	ToB	John Dudzik							er's Name (<i>First, Middle, Maiden Sumame)</i> 1exandra Bonczek						
T T	-	19a. Informant's Name/Relationship (T	vpe. Print)		19b. Mailin	n Address (St					Town, State, Zip Code)				
tra	1.9	Lynne Petrides - Da	,												
		20a. Method of Disposition	augitei	20b. I	Place of Dispos	ition (Name o	ad, Silv	er Spri		20c. Location		own State			
5		1 X Burial 2 Cremation 3 1		ate	cemetery, crem	atory or other	place)			Zoo. Coodiion	only of 10	JWII, SIEIO			
Ē.	1	4 Donation 5 Other (Specify,		Ro	ck Creek		-	4/5/20	07	Washing	ton, DO				
eny injury or on once.	- 1	21. Signature of Funeral Service Licens	988	000			ddress of Facili		e. Inc.						
• 4	Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, M									g, Mary	1and 20904				
ian ical ner	jr.	23a. Part1. Enter the disease, or comb shock, or heart failures. List only commediate Cause (Final disease or condition resulting in death) Sequentially its conditions, if any leading to immediate	a. Suspe Due to (or	obable eted My as a consec	Cardial (uence of):	Arrythm	thmia ia	Ortio				Interval Between Onset and Death			
	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq											
	Med	IF FEMALE:								J.					
	ysiclan/	ysiclan/	Physician/Med	ysiclan/	ysiclan/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year	
		Part II. Other significant conditions co	ntributing to dea	ulting in the un-	ing in the underlying cause given in Part I. 23e. Did tobac						cco use contribute to the cause of death?				
	<u> </u>	Ω	<u> </u>	Ω	Diabetes Mellitus							1	s 2 No	3 Prob	ably 4 Unknown
	e e	Acute Bronchitis							24a. Was ar	24b	24b. Were autopsy findings available				
8	Completed	Acute Bronchittis		autopsy perform						y ned?	prior to cor death? 1 \(\sum \text{Yes} \)	mpletion of cause of			
	0	25. Was case referred to medical			26 Pla			e of Death //			10.63	20 100			
	0	examiner? 1 ☐ Yes 2 🕱 No	fospital: 1 ☐ Inp	atient 2 🗆	tient 2 ER/Outpatien		04		th <i>Check only one</i> ome 5 ☐ Residence 6 ☐ Other ((0 4				
- 1.	=	27. Manner of Death	28a. Date of		28b. Time of	3□ DOA 28c. I			I. Describe ho			/)			
	Certification:	1 SNaturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Intury	Work? M 1 Yes 2 No					t and Number or Rural Route Number.						
	Cerr	4 Homicide determined building, etc. (Specify)							, State)						
	Medica	29a. Certifier (Check only one)	sician: To the be ner: On the basi and manner	s or examina	wledge, death tion and/or inve	occurred at the estigation, in n	e time, date an ny opinion, dea	nd place, and th occurred	due to the ca at the time, da	use(s) and m ite and place,	anner as st and due to	ated. the cause(s)			
	Σ	29b. Signature and title of certifier).			29c. Lic	ense number		29	d. Date signe	ed (Month, I	Day, Year)			
		1 July	<h< td=""><td></td><td></td><td></td><td>D24035</td><td></td><td></td><td>April 2</td><td>2, 2007</td><td></td></h<>				D24035			April 2	2, 2007				
- 1	- 1									2	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** April 4, 4:30 P M Henry L. Bowie Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerford House Frederick Frederick 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Yrs. 579-26-7454 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 X Yes 2 No ms 23a or 28a-f sh must be notified Directo Rockville Maryland | Montgomery the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1416 Thornden Road 20851 United States 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Ite 1 ⊠Yes 2 □ No World
If Yes, Give
Year or Dates: War II 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 C & P Telephone Service Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Louise Landry Henry L. Bowie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark F. Bowie/ Son 11826 Ridge Way Drive, Monrovia, MD 21770 permit. Pages 1 and 3 Department of Health Important: If Item 27 I any injury or other tra once. 20b. Place of Disposition (Name of cemetery, grematory or other parte of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition April Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Livens Deer Park Drive, Gaithersburg, Maryland 20877 23a. Part f. Enjeting as ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart it is e. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Due to (or s) onsequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 ☐ Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown oran on 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence AssistAd Hospital: P 1 ☐ Yes 💃 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify 28a. Date of Injury (Month, Day Year) ng Faau 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 Yes 2 No neral Director: A death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5

20

DHMH 17 Rev 1/2001

State

Registrar

denc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

honson

The

APR 06

31. Date filed (Month, Day,

State Registrar DHMH 17 Rev 1/2001

JANET N. SCHEEL, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 NORTH BAUTIM OUTE

2007

519

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 5:20 A^M Edith Mae Baker April 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Genesis Waldorf Center Waldorf Charles If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F 82 March 24, 1925 Director 220-16-6313 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 27 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Cambridge Drive 20602 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.
tem 27 is marked other than "natural", or Ite 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Child Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Webster Mahaney Mary Helen Schriver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a. Important: If Item 27 Is any injury or other trau once. 1104 Cambridge Drive Waldorf, MD 20602 Mary E. Pate/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4/9/07 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) OM00817 22. Name and Address of Facility
Arehart-Echols Funeral Home, 21. Signature of Funeral Service Licens P.O. Box 567 La Plata, MD 20646 Approximate Interval Between onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 2 No 9□Unknown 9 ☐ Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 № No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Certification: 1 🗷 Natural 5 ☐ Pending investigation after death.

Director: Af
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide

.O. Box 68760, ٦. or Vital Records, Division

or Attending within 24 hours after To the Funeral Dire Hospital

MP 5

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s)

12070 OLD Registrar's Signature

P.O. Box 68760

Baltimore, Maryland 21215-0036

Division or Vital Records, Hospital or Attending P 24 hours after death. Funeral Director: After t within 24 hours at To the Funeral

> State Registrar

Medical

MELVIN GASKINS 31. Date filed (Month, Day, Year) APR 09

30. Name and address of person who

4 ☐ Homicide

(Check only one)

29a. Certifier

7831 BELLE POINT OR GREENBELT, MD 32. Pegistrar's Signature

completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registract PLD#8perFH4/1 1. Decedent's Name (First, Middle, Last)	State of Marylan 3/07, EMW., MoCo		artmen rtificate					g. No.	007	1 2 7 8 9
	Physici /Medic		Robert Emmons	Cyrus					(Month 04/02/	2007		1:00pm M
	Examir	er	4a. Fecility Name (If not institution, give s 822 fairoak Av	е		Hya	tts	ville	е		Pri		s George
	Funeral Director		5. Social Security Number 6. Sex 149-14-1027A Usual Residence of Decedent	7. Age (In yrs. 78	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	⊋ _₽ 04-2 2-8		place (State or Foreign intry) st Virgini
Maryland	ied at	tor	10a. State 10b. County	eorge's Hya	y, Town or Lo		-						10d. Inside City Limits 1 Yes 2 No
h with the	3a or 28a at be not	Funeral Director	10e. Street and Number 822 Fairoak A	ve		10f. Zip	Code 1078	3		10	_	of What Cou	untry?
5-UU36 72 hours after death with the Maryland	piene rithen "naturel", or Items 23e or 28e-f ehow the Madical Examiner rount he notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was D <i>e</i> cedent Ever in U. Armed Forces? 1		Was Deced f Yes, spec 1 ☐ Yes	_	ispanic Orig n, Mexican Specify:	gin? (Specif , Puerto Rid	ly Yes or No- can, etc.)		Race - Amer Black, White ecity: B	
	al Hygiene. I other then "natur vent, the Madical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		dent's Usua kind of woi DO NOT us	rk done d se retired	ation during most)	of working	1		of Business/	·
aryland 2 should be filed	d other	To Be C	17. Father's Name (First, Middle, Last) Emmons Cyrus							First, Middle, M Gillu		mame)	
and 2 sho	of Health and Men Item 27 is marke other treumatic	1	19a. Informant's Name/Relationship (Ty, Edith Silverstei	n-Cyrus Wif	e 8	22 F	air	oak i	Ave I	Route Number, Hyatts	vill	e,Md	20783
Baltimore, Dermit. Pages 1 ar	Depertment of Himportent: If Item any Injury or oth 2000.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	OHIOVAL HOIN STATE	lace of Dispo emetery, cren cyland	d Vet	era	ıns ⁰	4/09	/07 (helt	on-City or T tenha	m,Md
Dean Permit	Depert Import any In		21. Signature of Funeral Service License		14	109 E	air	lake	s Pl	Ste E	Mit		vice,P.A. lville,Md
/1	ysician and Medical the burial-transit	ical Examiner	23a. Part1. Enter the disaase, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Prostate (Due to (or as a consequence to (or a))).	Carcinuence of):		o oi ayiii	y, such as c	ardiac of it	espiratory and	51,		Approximate Interval Between Onset and Death
death certific	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3□	Ectopic pro					23d.	Date of deliving	very Day Year
	5 2	۵	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying ca	ause give	en in Part I.					the cause of death?
T P	cate has been s , page 2 should	Completed								24a. Was an autopsy perform	ed?	4b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
r VILC	this certificate ha	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DO	A Othe			Check only one 5 Resider		Other (Speci	(fy)
VISION OF VITA Attending Physician:	After t funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at ? /es 2 N		d. Describe how	v injury oc	curred	
בַּ ב	irs effer deat ral Director; led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory	, office		28f	Location (Stre City or Town,		umber or Rui	al Route Number,
ne Hospit	othe Funaral Dir	edicai	29a. Certifier (Check only one) 2 Medical Exemination	icien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	i place, and h occurred	d due to the cau at the time, da	use(s) and te and plac	d manner as ce, and due	stated. to the cause(s)
To the	ompide district	Σ	29b. Signature and title of certifier	3 1 2 6 6 :+-				number		1		gned (Month	
5	4		30. Name and address of person who col	mpleted cause of death (Item	23a) (Type,		D23	743			Apri	11 3,	2007
	Sta Registr		Martin Weltz, M 31. Date filed (Month, Day, Year) APR 0 4 20	32. Angistrar's Signat	ture	у Се		r Dr	ive	Green	pelt	,Mary	land 2077(

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		artment of I <i>rtificate of</i>			giene Reg. No.		
			1. Decedent's Name (First, Middle, Last,					2. Date of De	eath	200	3. Time of Death
я	Physici /Medic	162	KENNETH	CO	REY			MARCH	31, Day	2007	11:15 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	4c. C	County of Deatl	h
			4207 Bel Pre Road			Rockvi				lontgom	
	Funeral		5. Social Security Number 6. Sec	M STE	last birthday) Yrs.	If Under 1 Year Months Days		. (Month, Da	ay, Year)	Col	nplace (State or Foreign untry)
	Director		026-24-9192 Usual Residence of Decedent	73	110.			Aug. 2	9, 193	3 Mas	sachusetts
	land ow at		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mary i-f sh fied	į	Maryland Montgome	rv Roc	kville						1 X Yes 2 ☐ No
	or 28g	ire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?
	th will	Funeral Director	4207 Bel Pre Road	<u> </u>		2085	3			ed Stat	
	r dea	lae	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	D- 14	 Race - Amer Black, White 	
36	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 No If Yes, Give KORE Year or Dates:	AN	1⊡Yes 21☑No	Specify:		5	Specify: W	hite
21215-0036	hour tural al Ex		15. Decedent's Edu		16a, Dece	dent's Usual Occu	nation		16b. Kind	d of Business/I	Industry
5	in 72 "na" r ledic	lete	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking			
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sales	man			Gene	eral Sa	les
	be filed within 72 hours after death with the Marylan stal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ıme (First, Middle	, Maiden S	Jurname)	
/lar	should be and Mental some marked or umatic ever	To E	Lute Wellington (lorey			Norma M	ildred V	Theele	er	
Maryland	2 sho and l		19a. Informant's Name/Relationship (Ty	rpe. Print)	L		t and Number or F				(ip Code)
	and ealth n 27 ier tr		Lillian H. Corey	(Wife)			Road, Ro	ckville,			
ore	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F	removal from State		sition (Name of matory or other pla	1			ation - City or	
Baltimore,	it. Pa rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify)		ropoli	tan Cre	natory 4/ ess of Facility D	3/0/ eVol Fur			Virginia
Ba	permit. Pages: Department of I Important: If ite any Injury or of		1 New Years	Allel L		0 East D	eer Park	Drive			
P	×,		23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the death					arrest,		Approximate Interval Between
V.	Physician		Immediate Cause (Final disease or condition	EMPHYSEMA							Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequ	uence of):						
r.	Examiner	<u>_</u>	Sequentially list conditions,	b Due to (or as a consequ	uanna off:						
	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury	Due to (or as a consequ	derice oi).						
	al-trai	xar	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
68760,	ficate be executed physician and s the burial-transit	cal		d							
.89	+ m	edical		4							
Вох	death certific e attending p d for use as 1	Š	230. Was decedent pregnant	23c. If yes, outcome pf pregna 1□Live birth 2□Feta		∃Ectopic pregnan	CV		23	3d. Date of deli	,
	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d		Other (specify)				Month	Day Year
P.O	The law requires that the de ate has been signed by the a bage 2 should be detached	Physician/M	9 Unknown		ulaine in Abeniu		ives is Deat I	220 Did	Anhanan un	o contribute to	the cause of death?
	res tha signed be def	ρ	Part II. Other significant conditions co	nthouting to death but not rest	uiting in the u	ndenying cause g	iven in Part I.			l No 3 □ Pr	v
Vital Records,	w requir been si should b	Completed						-	ī		
Sec.	e law has b	nple						24a. Was	psv	24b. Were au	topsy findings available completion of cause of
al F								1 Yes	ormed? 2 X No	death? 1 ☐ Yes	2 🕱 No
Vit	Physiclan: r this certificaral director, I	Be	25. Was case referred to medical examiner?	Hospital:			hor	eath (Check only			
o		-T	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatier 28b. Time o	" 3 D DOX	4 🗆 Nursing	Home 5 Res			cify)
on	Attending I r death. sctor: After by the funer	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Inju Wo M 1[ork? ∐Yes 2∐No		,		
Division	of or Attendated after death	fica	3 Suicide 6 Could not be determined	28e. Place of injury - At ho	ome, farm, str	eet, factory, office		28f. Location	(Street and	Number or Ru	ural Route Number,
ă	al or s after al Direction bed in b	Certification:	4 [] Homicide	building, etc. (Specif	y)			City or 10	wn, State)		
	To the Hospital of within 24 hours at To the Funeral Completely filled it		(Check only 2 Medical Exam	rsician: To the best of my kno Iner: On the basis of examina							
	thin 2, the I	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licer	ise number	T	29d. Date	signed (Monti	h. Dav. Yearl
	5 # 5 p		1010.2141	110		MD# 3				L 2, 20	
	0+1		30. Name and address of person who c	ompleted cause of death (Itan	n 23a\ /Tune	Print)					
			KAREN ANN BLACKSTO				STREET NW	, WASHII	NGTON	DC 204	22/688
г	Sta	ate	31. Date filed (Month, Day, Year)	32 egistrar's Signa	turo	ant o					

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

APR 06

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I		Re	eg. No. 2007	12792				
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Gertrude Iv					2. Date of Deat Month April 6,	Day Year	3. Time of Death 2:20 p.m.M				
	/Medic Examir		4a. Fecility Name (If not institution, give Golden Living			4b. City, Town, o	or Location of Death	APITI 0,	4c. County of Death Frede)				
	Funeral Director		310 10 3000	TM OFIE	e (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January		nplace (State or Foreign intry) Illinois				
	Maryland I-f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Frederi	ck	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 3 ☐ No				
	h with the	ai Director	10e. Street and Number 4309 Flower Court			10f. Zip Code	769	10	0g. Citizen of What Cou USA	untry?				
36	72 hours after death with the Maryland 'naturel', or Items 23a or 28a-f show dical Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 Tyl If Yes, Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:					
Maryland 21215-0036	S _ 9	Completed t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of work	ring	 16b. Kind of Business/li	ndustry				
2	filed with Hygiene. other than			2		istrative		- (5:)) (3:)		ion				
ylanc	be data	To Be	Elvy Leland McCo				Lyd	la Buchar	nan					
Mar	S D F F				74.	_								
	es 1 an of Heal of Item 2 r other		20a. Method of Disposition 1 Burial 2 XCremation 3 F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	сө)	Date 2	20c. Location - City or T	own, State				
Baltimore,	permit. Page Department Importent: If any injury of once.		17. Father's Name (First, Middle, Last) Elvy Leland McConkey 19a. Informant's Name/Relationship (Type, Print) Sharon Rejonis — daughter 20a. Method of Disposition 1 Burial 2 IxCremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 21. Signative of Funeral State 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 18. Mother's Name (First, Middle, Maiden Sumame) Lydia Buchanan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Feldspar Road, Middletown, Maryland 217 20c. Location - City or Town, State cemetery, crematory or other place) Stauffer Crematory 21. Signative of Funeral State Clicenses 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate Company of the complex of the company of the											
			23a. Part 1. Enter the disease, or compl	ications that caused	the death. Do not er					Approximate				
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ATHEN	a consequence of):	Cononi	my ARTI	ony Di	SEASE	Interval Between Onset and Death				
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequence of):	o THUI	VE							
.O. Box 687	death certifi e attending I id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \) Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc	y		23d. Date of delik Month	very Day Year				
S, D	og pe	by	Part II. Other significant conditions col	ntributing to death b	ut not resulting in the	underlying cause gr	ren in Part I.		acco use contribute to					
of Vital Record	The law ete has b page 2 st	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to co	opsy findings available ompletion of oause of				
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one	9)					
on of	ding Phys h. After this funeral di	tion; To	1 Yes 2 No 27. Manna of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injui (Month, Da)	nt 2 ER/Outpatie 28b. Time of Year) Injury	of 28c. Injur	y at	ome 5 Resider 28d. Describe hor	nce 6 Other (Speci w injury occurred	ify)				
Division	in Dire	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubul	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	reet and Number or Rui , State)	ral Route Number,				
	Hog Fur b	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/or is	th occurred at the timestigation, in my o	пе, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)				
	To the within 2. To the complet	ž	29b. Signature and title of certifier			29c. Licens		ľ	d. Date signed (Month)					
			- 7mm)			D	17951		4-06-0	7				
	12		1100	MI. MD			= AUF	Frene	enuch t	1021701				
	Sta Registr		APR 0 9 2007	Registra	ar's Signature	meli								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** CLARK ARRIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLS TOUR HOSPITHE CENTO ALTIMORZ MONTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Country 82 219-10-3822 Director May 10, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at Maryland Baltimore 1 ☐ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 or items 23a 3410 Kimble Road United States Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Examiner ☐ Yes 2 f Yes, Give 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 □ Divorced natural", Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 sal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil h and Mental H 7 Is marked ott Be D. Lloyd Stoker 2 Arria Rush 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health James Stoker Brother 3501 Offutt Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H-Important: If Iter any Injury or oth 1 ☐ Burial 2XX remation 3 ☐ Removal from State South Carroll Crematory April 2, 2007 Winfield, MD 4 ☐ Poquation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, PA

1212 W. Old Liberty Road Winfield

art1. Enter the disease, or complications that cay ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death immedia Cause (Final diseas or condition res ing in death) **Physician** EHyDRATION SIVENE /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ GANTIOCN TOSTENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy page near LATTER TO 10 Yes 2 LENO
26. Place of Death (Check only one) perform THIPER TENSION Division or Vital or Attending Physician: director, Be 25. As case referred to medical examiner? 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient မ After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural Injury within 24 hours after deaus.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P JA HESPITAL CONTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ORGENDO B. CONTRAN MD 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar 05

DHMH 17 Rev 1/2001

Amended Item 20b per F.D. 04/13/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 03 2007 **Physician** 4:36p M Hilda Mae Campbell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ctr Brinton Woods Nursing and Rehab Carroll <u>Sykesville</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 X 235-18-1794 Director W.VA Sept 01 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □ Yes 2 □ **X**o Director Westminster Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 969 Pinch Valley Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ **X**o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 9 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Burnes & Russell Executive Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lily Skidmore Andrew J. Piercy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Westminster, MD21157 Carol Ann Gavigan/daughter 969 Pinch Valley 20b. Place of Disposition (Name of cemetery, crematory or other place) Cem 4/6/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans │ Owings Mills, MD 21. Signature of uneral S Pritts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster, MD21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Regenerative Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRACT WRETION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Privaring Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760,

The law requires that the death certificate be executed attending physician I for use as the buria Division or Vital Physician:

filed within 72 hours after death with the Maryland Hygiene.

Maryland 21215-0036

"natural", or items 23a or 28a-f show idical Examiner must be notified at

, or

Medical

event, the Me

Physician

/Medical

Examiner

burial-trar

To the Hospna. To within 24 hours after death.

To the Funeral Director: After this or managed in by the funeral director.

State Registrar

29a. Certifier

29b. Signature and fitte

31. Date filed (Month, Day, Year)

APR 05

of certifie

29d. Date signed (Month, Day, Year)

- ws 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000 Libinary RD ELDENSBURG ND 21784

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place and

1 Legrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2007

SUITE 102

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 06:03^{AM} LEE 03 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Peningula Regional medical WICOMICO Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Yrs. 5. Social Security Number **Funeral** Min Months Davs Hours 1**€** M 2 ☐ F 219-03-2329 Usual Residence of Decedent MD Director filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director SOMERSE 55 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2185 JSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR DOMERSE 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ဂ္ COTTMAN DUJARD HAMILTON HRISTIANNA OTTMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318-SILVERTHORNERD Date BALTIMORE, MD 21237 - 3435 te 20c. Location - City or Town, State KERLAN COTTMAN-MORGAN-DAUGHTER Important: If Item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State TAN CEMETERY 4-9-07 PRINCESS ANNE MD 22. Name and Address of Pacility BENNIE SMITH FIH METROPOLITAN CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Sign dure of Funeral Service Licensee MD 21801 a ISABELLA ST: SALISBURY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stag Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed sician and burial-trans Due to (or as a consequence of): physician a Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate 2 ☐ No 2X No Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<mark>X</mark> № 1 ☐ Yes 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or

-03-23

State Registrar 31. Date filed (Month, Day, Year)

2007

ddress of per

Signature and title of o

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

29c. License number

2056197

29d. Date signed (Month, Day, Year)

Salisba

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month DUBROWSKY 3:30aM MARIA 2007 April 02 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery Fairland Nursing Home Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days Min. 87 057-32-3624 Ukraine Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 U.S.A. 9510 Saybrook Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ⅓Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Language & Literature Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ivan Hudzenko Motrena Hudzenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Lomacky - Daughter 9509 Vance Place, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gedar Hill Cemetery 4/4/2007 Suitland, Maryland 21. Signature of Funeral Service Lights HINES-RINALDI FUNERAL HOME INC. Nanu 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Lymphoma resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebral Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2√ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only оле Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner inding physicien and use as the burial-transit Box 68760, ō Records, P.O. detached page 2 s Division of Vital funeral director, this After

Physician

/Medical

Examiner

Directo

Completed by Funeral

Be ٩

Examiner

by Physician/Medical

Completed

Be

٩

Certification:

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Funeral

Director

Mode

d other than "neturel", or iteme 23a or 28a-f ehovevent, the Madical Experies at

Peges 1 and 2 should be filed within 72 hours atter death with ment of Health and Mental Hygiene. And It Item 27 is marked other than "neture!, or Iteme 23e or usy or other traumatic event, the Munical Expinites runal bar.

permit. Pege Department of Important: If any injury or once.

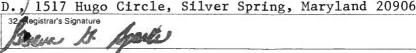
Pnysician

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Japitar James 4 hours after deam. 24 hours ? npletely To the

> State Registrar

Alan R. Segal, M.D. 31. Date filed (Month, Day, Year) APR 04



DARU

30. Name and address of person who completed cause of death (Item 23a (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D52261

29d. Date signed (Month, Day, Year)

April 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ^{Day} 2007 Month Physician March 31, 5:28 P_M Arnold Dorfmann Jacques /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arden Courts Potomac Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Birthplace (State or Foreign Country)
 CT Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 09/07/1925 047-16-5529 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 XNo MD Kensington Montgomery Director 10g. Citizen of What Country?
United States 10e. Street and Number 3311 Oberon Street 10f. Zip Code 20895 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 □ No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify: White WW II Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Shirley Berman Paul Bernard Dorfmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Dorfmann - Son 3311 Oberon Street Kensington MD 20895 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garden of Remembrance Memorial Park 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/2/07 Clarksburg, MD 22 Name and Address of Facility Edward Sage Funeral Direction 1091 Rockville Pike Rockville MD 20 52 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to infinitionate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d Prostatic Hyperplasia 1 Yes 2 No 3 No Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Hyperlipidemia has page 2 autopsy performed? death? 1 ☐ Yes certificate 2 □ No 1∐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral within 24 hours a

> State Registrar

Gary E. Raffel,

31. Date filed (Month, Day, Year)

APR 04 2007

DHMH 17 Rev 1/2001

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

FACP

DO.

29c, License number

5411 W. Cedar Lane, #202A Bethesda, MD 20814

H45839

29d. Date signed (Month, Day, Year)

April 1, 2007

State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Irene April 1, 2007 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12704 Deep Spring Drive Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 □ M 2 X F Yrs. Director 216-80-2310 63 Russia July 5, 1943 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State woye 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural, or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2K No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12704 Deep Spring Drive 20854 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education other treumatic event, permit. Peges 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth eny lipiny or other treumatic event Size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Andrew Knish Nina Unascertainable 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Dolgun - Son 12704 Deep Spring Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete Parklawn Memorial Park & 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2007 Menorah Gardens Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. udewia manda 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetel de 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetel death 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete has been sign, page 2 should be Completed 1 Tes 2 No 3 Probably 4 BUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 2 No 1 ☐ Yes 2 No Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation м 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 0 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D61877 April 2, 2007 person who completed cause of death (Item 23a) (Type, Print) Anu Singh, M.D., 9711 Medical Center Drive, Suite 111, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 egistrar's Signature State APR 06 2007 Registrar

			State of Maryland / Dep	artment of Health and Mer		COUI ITIDD							
ì	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	ay Year 3. Time of Death							
	/Medic		Richard Joseph Dent	T	April 5,								
!"	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death							
			Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Prince George's 9. Birthplace (State or Foreign							
l.	Funeral Director		236-28-1125	Months Days Hours Min.	Date of Birth (Month, Day, Year 20, 1	1924 Clarksburg, WV							
	D		Usual Residence of Decedent										
	arylar ehow	-	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 11 Yes 2 □ No							
	Ba-f	ecto	9	ver Hills	10.0								
	a or	by Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?							
	deeth	era	4303 74th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20784 Was Decedent of Hispanic Origin? (Specify	Yes or No-	USA 14. Race - American Indian,							
٥	or itan	Fun	1 Never Married 2 Married 1 2 Yes 2 No WW LL	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	an, etc.)	Bfack, White, etc.							
3	hours after deeth with the Maryland tural', or itama 23a or 28a-f ehow al Examinar pust by multipu at	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WILLE							
21215-0036	"natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working		Kind of Business/Industry							
7	within 72 ene. than "nai	ш	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Administrator		ntgomery unty Schools							
2	filed Hygi Sther	Ö	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi									
au		To Be	William J. Dent	Neta Shir	nn								
Maryland	d 2 should I th and Meni 7 is marked traumatic	_	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip Code)							
	and 2 Belth a n 27 la			Woodmont Road, Great		n, WV 25422							
9	I te		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	osition (Name of Date matory or other place)		Location - City or Town, State							
Ē	nit. Pages vartment of ortant: If it injury or o		4 □Donation 5 □Other (Specify) Fort Line	oln Cemetery 4/10/2									
Baltimore,	permit. Page Department Important: If eny injury or once.			2. Name and Address of Facility		739 Baltimore Ave.							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en			yattsville, MD 2078							
	.		shock, or heart failure. List only one cause on each line.		opilatory arrest,	Interval Between Onset and Death							
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ephalopathy		2 doys							
	Examiner		Cordina arrest										
	D ==	ner	Sequentially list conditions if any, leading to immediate cause. Enter Undertying Dup to (or as a consequence of):										
	ecuted ind trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of the consequence of	No									
1,00	ate be executed hysicien and the burial-transit	E	Due to or as a consequence of): Republication of the control of t	مـــ									
200	physi s the	dical	d. Kines Pacific	<u> </u>									
ROX	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery							
	death e atte	ICIa	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5[□Ectopic pregnancy □ Other (specify)		Month Day Year							
r O	at the by th	hys	9 Unknown 9 Unknown										
ູ ທົ	requires that the een signed by th hould be detache	þ	Part If. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death?							
ecord	neen Jour	ted	Type 2 Dulsetes Mellit	V3	1 ∐ Yes 2	2 Mo 3 Probably 4 Unknown							
Yec Y	e law has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
	sicien: The law certificate has t irector, page 2 s		05.10		1□ Yes 2 PN	lo 1 Yes 2 No							
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	26. Place of Death (Co		0 TOU (0 (1)							
0	iding Phys th. After this funeral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of	f 28c. Injury at 28d.	Describe how inju	6 ☐Other (Specify) ury occurred							
0	Attending r death. actor: After by the fune	atlo	2 Accident investigation	Work? M 1 □ Yes 2 □ No									
UNISION	or Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	Location (Street a City or Town, Star	and Number or Rural Route Number, te)							
2	spital or ours afte eral Dir filled in	O											
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the bent of my knowledge deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and clade, and exestigation, in my opinion, death occurred a	it the time, date ar	and place, and due to the cause(s)							
	20	Σ	29b. Signature and title of certifier Daniel alexander no	29c. License number D 5 2 8 / 5	29d. D.	late signed (Month, Day, Year)							
	2/14		30. Name and address of person who completed cause of death (Item 23a) (Type,	D52815 Drive Cheverly	YUNO	70785							
	Sta	te	31. Date filed (Month, Pay-Year) APR 0 9 2007 Taken 32. Registrar's Signature	- City City	1,000	V 1 3							
	Registr	ar	WENT AS CAN Them No. Process										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2, 2007 **Physician** Ertischek 11:45A M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, 4/15/1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😾 F NY 053-14-2967 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No FLDirector Broward Plantation 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 33322 United States 8209 NW 13 Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 No Specify Specify. þ White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Torgoff Esther Olshenbaum ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4620 Norwood Drive Chevy Chase MD 20815 Debra Aronson - Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/5/07 Menorah Gardens Southwest Ranches, FL 4 ☐ Donation 5 ☐ Other (Specify) -Foldberg Memorial Fike Rockville 20852 22 Name and Address of Facility Danzansky Chapels Inc 11/0 Rodkville 21. Signature of Funeral Service Licensed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Glioblastoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes **X** No death? 1 ☐ Yes certificate 2 **_X**No To the Hospital or Attending Physiclan; within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Medical

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Silliamo DO

H005803Z

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road Rockville Md 20850 Cynthia M. Williams MD

State Registrar





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** AM **GLENDENA** CAREY **EDWARDS** 6:57 April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 7705 Killbarron Drive Laurel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M XXF 84 Yrs Aug.5, 1922 Director 102-22-8362 Florida Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Miami 1X Yes 2 No FL Dade Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Exception 2. 1480 NW 55th Terrace 33142 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ≱☐ No Specify: Specify: Black by 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dade County Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henrietta Morris Osborn Carey ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Edwards (Daughter) 7705 Killbarron Dr., Laurel, MD 20707 20b. Place of Disposition (Name of cemerery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Memorial Pk 4/13/07 Miami, FL 4 Domation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sign Funeral Service Lices 246 N. Washington St, Rockville, MD 20850 Part T. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. benter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Pancreatic Cancer 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🙀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part (23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Daughters Other: 4□ Nursing Home 5□ Residence 6 ☑ Other (Specify) Home 1 Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident

Examiner The law requires that the death certificate be executed as the burial-tran and Box 68760 attending physician P.O. I ate has been signed by page 2 should be detac Division or Vital Records, certificate or Attending Physician: ours after death.

neral Director: A To the Hospital within 24 hours a To the Funeral I

the Maryland

with ö must be notified

28a-f

31. Date filed (Month, Day, Year) State 0 4 2007 Registrar

Sara

C.

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

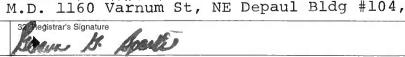
(Check only one) 29b. Signature and title

6 Could not be determined

of certifi-

Horton,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

D30188

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

DC

Washington

20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GILBERT DENNIS FISHER 16 2007 APRIL 7:40 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊻** M 2□ F 222-22-3173 Director 67 3 1939 Aug Delaware Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. hther than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director MD Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, 172 Center St. Apt. 3-D 21913 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Black \$ 3 ☐ Widowed 4 ☐ Divorced 1963 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmhand Farming 10 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill treent of Health and Mental H tant; If item 27 Is marked ott permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any Injury or other traumatic ev William Fortner Fisher Helen Mae Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Davis (daughter) 41-11 Harbor Dr. Claymont, DE. 19703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Kent Cremation 4/21/07 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 21. Sign dure of the all Surface Line no Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cau (Final disease or concition resulting in death) **Physician** 200515 /Medical Due to a consequence of): **Examiner** HEVMOUIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ENDOCARDITI physician at s the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical ast attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (HROWS DY DOWN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No 24a. Was an MALNUTRI 710N has autopsy performed? this certificate MOOM 1□ Yes 2□ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Homicide within 24 hours a To the Funeral I Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar 30. Name and address of p

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

CHORATORNS

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav 2007 Mary Louise Fankhauser 11:30 A /Medical April 5. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel County South River Health & Rehabilitation Edgewater 8. Date of Birth (Month, Day, Ye Aug. 15, er 1 Year Davs If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 F Months Hours 1923 Washington, DC Director 212-62-1340 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Co. Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 196 Main Street 20711 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify Completed by Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ Lillian Grisby James Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 196 Main Street, Lothian, Maryland 20711 Carolyn Carroll (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 10, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Vets. Cem. 2007 Cheltenham, Maryland 21. Signature of Fu 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔁 Natural (Month, Day Year) 1 🗌 Yes 2 🗌 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State

Registrar

32. Registres Signature

0

Division		1 - For State Registrar Amend #1 1. Decedent's Name (First, Middle, I		Agnes	Fabert					2. Date of De Month	ath Day	y Year	3. Time of Death
Physicia /Medic		Taber	*4	Agno	25					April .			3:35 A. M
Examin		4a. Facility Name (If not institution, g	rive street and num	nber)		4b. City,	Town, or	Location of	of Death		4c.	County of Death	n
		Homewood at Cru					deri		O.4 Men			redericl	
Funeral Director		245-68-0610	Sex 1 □ M 2 1 F	7. Age (In yrs. 90	Yrs.	If Under Months		If Under: Hours	Min.	8. Date of Bir (Month, Da June 7	y, Year) , 19	9. Birth Con Eng	nplace (State or Foreign untry) Land
***		Usuel Residence of Decedent 10a, State 10b, County			ty, Town or Lo								10d. Inside City Limits
r 28a-f show	ctor	Maryland Freder	ick	J	effers	on							1 ☐ Yes 2 No
ms 23a or 28a-f show	Funeral Director	10e. Street and Number 4426 Teen Barnes	Road			10f. Zip 21	755				-	izen of What Co SA	untry?
er m	uner	11. Marital Status	Armed Fo		l.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	 Race - Ame Black, White 	
ral, or l	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	I 1 □ Yes If Yes, Giv Year or Da	е		1 ☐ Yes	2 X No	Specify:				Specify: V	white
ane. than "natural", or Ite te Medical Examina	Completed	15. Decedent's (Specify only highest)			16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation <i>luring m</i> osi	t of worki	ng	16b. Ki	ind of Business/l	Industry
ital Hygiene. id other than "n event, Ita Med	dwo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Nurs		30 701#80,	,			Me	dical	
d other	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle	Maiden	Sumame)	
and Mental Hygiene. Is marked other than aumatic event, tre M	ToE	Leonard Howard							a Le				
of Health and Menitem 27 is marks other traumatic		19a. Informant's Name/Relationship Harry Fabert - h			4426	Teen	Barn	es Ro			-	n Town, State, 2 Marylar	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State Sta	Place of Dispo cemetery, cre uffer	osition (Nan matory or o Crema	ne of ther place tory	e) (04/09	9/2007		erick, M	Town, State (aryland
Department of Important: If eny injury or once.		21. Signalu of Funeral Service Luc	7	10	2	2. Name an	d Addres	s of Facilit				neral Ho ick, Man	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that c	aused the deal								ick, mai	Approximate
hysician		Immediate Cause (Final disease or condition		rasta									Interval Between Onset and Death
Medical		resulting in death)		or as a consec		(70	(0,)	> '		ATTECY			
xaminer		Sequentially list conditions,	b										
sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ui as a cuiissu	quenică ul).								
ician and burial-transil	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):								
5 e	cal		d										
attending phy for use as th	/Med	IF FEMALE:	23c. If yes, out	come of aroon	2004								
by the attenditached for us	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live b	irth 2☐Feta ant at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp				-78		23d. Date of deli Month	rvery Day Year
signed by d be detac	by Ph	Part II. Other significant conditions	s contributing to de	eath but not res	sulting in the s	ınderlying c	ause give	en in Part I.		23e. Did t		500	the cause of death?
ate has been signed by the attending phi page 2 should be detached for use as th	eted									ļ		^	
page 2	ompi									24a. Was auto perfo		prior to death?	topsy findings available completion of cause of 2 No
certificate rector, pag	BeC	25. Was case referred to medical	1					26. Place	of Death	(Check only		1 10.00	20.10
this ce al direc	To	examiner? 1 ☐ Yes 2:☑ No	Hospital: 1 □ I	npatient 2] ER/Outpatie	nt 3 DC	Othe OA	90: 4 (X/Nu	rsing Ho	me 5□Resi	dence	6 □Other (Spec	cify)
r death. ector: After this certifica by the funeral director, p	:uo	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work	c ?		28d. Describe	how injur	y occurred	
tor: /	cati	Accident investigat 3 Suicide 6 Could no	h.	of laive. At la		M de state		Yes 2		29f Location /	Straat on	d Number of Br	ıral Route Number,
after of Direct d in by	Certification;	4 Homicide determine	ed 286. Place buildi	of Injury - At h ng, etc. (Speci	iome, rarm, st ly)	reet, ractory	, опісе			City or To	wn, State	e)	irai Houte Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		29a. Certifier (Check only Medical Ex	Physician: To the aminer: On the ba	best of my kno	owledge, dear	h occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and manner as	stated.
within 24 To the F complete	Medicai	one) 29b. Signature and title of certifier	and man	ner stated.				number				te signed (Monti	
To		29b. Signature and title of certifier	Ø	in a h					17		250. Da	le signed livorial	i, Day, rear)
		30. Name and address of person wh	on completed cours	e of death (Ite	m 23a) /Tuca		000	60 U	1/		7	121)	9 . 7 . 10
)		Hemen Shall	1 65	C I Jean (Hel	hema	S 32	hn	con	D	v. P	VE	devir	1 21702 MA
Sta	te∛ ar	31. Date filed (Month, Day, Year)	9 2007	egi rar's Sign									
	-	APK N	9 700V	Ballian .	M	Manual	N .						

D.O.D. 4/5/07

Fabert, Agnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WALTER GAVER APRIL 12 2007 9:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1**⋈** M 2□ F Days 83 Director Dec. 14,1923 217-18-7832 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show or 28a-f show 1 X Yes 2 No Directo Maryland Frederick Woodsboro 10f. Zip Code 10g. Citizen of What Country? o e Hygiene. other than "natural", or items 23a ent, the Medical Examiner must t 11 Rosewood Ct. U.S.A. 21798 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cable maintenance anould be filed المجاهدة - ما Mental Hygie. عال 77 is marked other th. عال traumatic وبوست 11 telephone co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any Injury or other traumatic ew onee. Morris E. Gaver Lulu I. Stull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Rosewood Ct., Unit 101 Cleora M. Gaver/ wife Woodsboro, MD 21798 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Olivet Cemetery 4/16/2007 Frederick, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Hartzler Funeral Home (a) Harine 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that arised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONARY DISEASE YKS HE ART /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit Due to (or as a consequence of): Box 68760, physician The law requires that the death certificate be Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by HYPERTENSION, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES been si STENOSIS, GERD 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s perform 1□ Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier Jonelvon 021936

5

State Registrar 31. Date filed (Month, Day, Year)

THOMAS VOHALON DE. 65C 2. Registrar's Signature

A. DINELSON, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK NO 2170Z

07-02744 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK	F	- For State			Maryland .		tificate of			Menta		F	Reg. No	200	1	1280
Physician Medical Examine	~	1. Decedent's Name Janae		iles		4						Date of De Month April 10, :		Year		of Death O hrs
		4a. Facility Name (it			et and number)			•		ocation of		др пп то, .	4	c. County of Deat		
	Ļ	Prince Geor				. // 1		Chev		Light	0.41.1	0 Data of D		Prince Georg		State
Funeral Director		5. Social Security N		6. Sex	_	e (in yrs. ia	ast birthday) 22 Yrs	Month	er 1 Year S Days	If Under Hours	Min	April		/DD/YYYY) 9. Bi 1984 C	gn	Md.
any	_	Usual Residence of 10a. State	Decedent 10b. County			10c. City,	Town or Locat	ion							10d. Ins	ide City Limits
*	_	Md.	PG			Gle	enarden								1 X Y	res 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Nur	mber		•			10f. Zip	Code					tizen of What Cou		
th the?		7913 Joh	nson Av						2070		212			ted Stat		5)
death with the Maryland or items 23a or 28a-f shumust be notified at once.	Funeral	 Marital Status Never Marrie 	ed 2 Ma		Was Decedent	?				Mexican,		cify Yes or N ican, etc.)	0-	14. Race - Ame White, etc.	rican India	in, Black,
after de al", or ner m	by F	3 Widowed		or D	s, Give Year	X No	1 🔲	Yes 2	X No	specify:				Specify:Blac	ck	
hours : 'natura Exami		15. Decedent's Ed					16a. Deceder during m			on (Give ki DO NOT u			16b.	Kind of Business	/Industry	
5-0036 led within 72 hours after death with the Maryland tygene. other than "natural", or items 23a or 28a-f shuth Medical Examiner must be notified at once	Completed	Elementary/Seco	mary (0-12)	`	College (1-4 or a	5+)		Disp	atche	er				Private	9	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than an unatic event, the Medica numatic event, the Medica		17. Father's Name			•				1	8.Mother's	,	First, Middle,	Maide	n Surname)		-
2121 uld be fil Mental Fi marked c event,	o Be	Melvin E 19a. Informant's Na			Print \		19h Mailin	n Address		-		Giles	ımher (City or Town, Stat	e Zin Cod	(a)
AD 2 shou h and N 27 is n	-	Lynette			·		P.O.		714	20703		idi Nobio Ne	inibor, c	ony or roun, old	c, <u>Lip</u> 000	,
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati	Ì	20a. Method of Disp	-	3 🗆 🖪	amoval from St		Place of Dispos crematory or ot	ition (Na	me of cem			Date	20c	. Location - City o	r Town, St	tate
Baltimore, MD remit. Pages I and 2 sho Department of Health and Important: If Item 27 is njury or other fraumal.	L	4 Donation 5	Other Sp	ecify:	emovar nom se	.aic	rmony M	iem.	Park	-	4/19		_	Landover, Md.		
Baltimore, ME permit Pages I and 2 s Department of Health at Important: Iftem 27 injury or other traumi		21. Signature of Fu	neral Service	Licensee	m d									ards F.1		
Physician	1	23d Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho												Appro	ximate Interval	
/Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds													Detwe	Death
a Administ		or condition resulting		Due t	to (or as a cons	equence o	of):									
	Jer	Sequentially list co if any, leading to im cause. Enter Under	nmediate	Due I	to (or as a cons	equence o	of):									
	a E	(Disease or injury t events resulting in	hat initiated	c Due t	to (or as a cons	equence c	ıf):								+	
and and reassi	를 교			d										_		
60, at the properties of the content		UNPENDED			IENDED								10	3d. Date of delive		
ox 6876 eath certificat attending phy for use as the		IF FEMALE: 23b. Was decedent past 12 months		e 23	c. If yes, outco			etal death	3	Ectopic	pregnan	су	2	Month	Day	Year
leath ce attence for use	Sici		No 9 🗸 Unk	nown 4	Pregnant a death Unknown	t time of	5 O	ther (Spe	ecify)							
that the d		Part II. Other signi	ficant conditi	ons conf	tributing to deat	th but not r	esulting in the	underlyin	g cause gi	iven in Par	rt I.			o use contribute t	o the caus	e of death?
S, P. uires th	ed by					-									obably 4	
cords,	Completed											24a, Wa auto	s an opsy formed?	prior to	completio	dings available on of cause of
tal Rec		DE W							OC Filess	of Death (Charles	1 ✔ Yes				2 No
Vital sysician: this certif	o Be	25. Was case refer examiner? 1 ✓ Yes	red to medical	Hospi	tal: 1 Inpati	ent 2 🗸	ER/Outpatient	t 3 1		Other4		Home 5	Resid	dence 6 Oth	er:	
of \ng Phy	- 1	27. Manner of Deat			28a. Date of Inj (Month, Day) Apr 10, 2007	ury Year)	28b. Time of	Injury		y at Work	19	28d. Describe		njury occurred		
Sion Attendi death. ctor:	엹	1 Natural 2 Accident	5 Pend Inves	tigation			2200 hrs			es 2 🗸	No					
Division of Pipital or Attending Phouse after death.	Certification:	3 Suicide 4 ✔ Homicide		d not be mined	28e. Place of II (Specify) ca		ome, farm, stre	et, factor	y, office bi	uilding, etc		or Town	State)	and Number or F oster Place, Te		
84 = >	- 1	29a. Certifier 1			To the best of n	ny knowled					ice, and c	ue to the ca	use(s) a	and manner as sta	ated.	
To t with To t	Medical	29b. Signature and		and	manner stated				c. License					. Date signed (M		
		700	〜ソノ	U	7	(,	,		O.C.N	Л.E.			Ap	oril 11, 2007		
		30. Name and addr							-4 D-10		4D 040	01		<u> </u>		
ົ້ງ Sta	to.	Zabiullah Al			t Medical E		38	ın Stre	ei, Baiti	more, N	/IU 212	· · · · · · · · · · · · · · · · · · ·				
Sta Registr	ar	1) V R V (1 / 1 1 1 1 1 1 1 1 1														

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Oscar Gorman 1:50 A M Apr 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert 5. Social Security Number 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min. 214-28-3915 79 Director Maryland Sep 20, 1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Port Republic 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1395 Ball Road 20676 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thornton Gorman ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Johnson /Niece 1395 Ball Road Port Republic, MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/14/07 4 ☐ Donation 5 ☐ Other (Specify) Holland Cemetery Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac /Medical Due to (or as a consequence of): **Examiner** theroscieron andin vascular di uase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Renal in sulbiciency 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D 50653 4-6-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9YAN 5851 eale Churcht Road 31. Date filed (Month, Day 32. Registras Signature State 2007 ▶ Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Hattie Elizabeth Gross** 10:50 P Apr 4, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 X F 215-38-4721 87 Maryland May 28, 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Calvert Prince Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 240 Mason Road 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie O. Myers Moses Albert Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 729 Prince Frederick, MD 20678 Adelle Harris /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 04/10/07 4 ☐ Donation 5 ☐ Other (Specify) Sunderland, MD Calvary United Apostolic Church 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovaseulan Due to (or as a consequence of) Sougral

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

þ

Be Completed

ဂ္ဂ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the tunneral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, sauling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					Funtin
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowh		Ectopic pro			23d. Date of de Month	elivery Day Year
ted by Pt	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying ca	ause given in Part I.			o the cause of death? robably 4 Unknown
Comple					24a. Was an autopsy performed? 1 Yes 201	death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?	Unanital.			th (Check only one)		
2	TE Tes ZIANO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Other: 4 Nursing H	ome 5 Residence		ecify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, ste building, etc. (Specify)	eet, factory	, office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,
edical (29a. Certifier (Check only one) 18 Certifying Phy 2 Medical Exam	sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred a vestigation,	at the time, date and place, in my opinion, death occu	(s) and manner a and place, and du	s stated. e to the cause(s)	
M	29b. Signature and title of certifier	10 March	29c.	License number	ate signed (Mon	th, Day, Year)	

YOUSA MD 31. Date filed (Month, Day 32. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2417

Solomons Island

State Registrar

Joseph Frank Gross State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last)
Joseph Frank 3 Time of Death Physician/ Gross Month Day April 6, 2007 0206 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreian Months Davs Hours Director 02/22/1934 214-28-2775 73 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Calvert Lusby death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12788 Olivet Road 20657 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: Black Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Divorced f Yes, Give Year Yes 2 X No specify: 3 X Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Laborer Construction 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hill Gross Geneva Leonard Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lusby, MD 20657 Elaine Smith/niece P.O. Box 333 item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Eastern UMC Cem. 4/14/2007 Lusby, MD Donation 5 Other Specify: 22. Name and Address of Facility Sewell 1451 Dares Beach Rd 21. Signature of Funeral Service Licensee Funeral Home 1451 Dares Be Mades Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Thyroid cancer Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, I 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other, Residence 6 Other Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes မ No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 6, 2007 O.C.M.E. W m. D 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Modella) sistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April . 200 ^{Year} **Physician** Edward Louis Gross 4 0423 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Sept. 5, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 ₩ 2 □ F 59 219-46-8570 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinat must be realfied at 1 Yes 2 No MD Calvert Chesapeake Beach Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 3144 Dalrymple Road 20732 USA Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Edward Gross, Jr. Ernestine Jones ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is any injury or other treu 2005 P.O. Box 604 Chesapeake Beach, MD 20732 Ernestine Jones/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jones Cemetery4/11/2007 Chesapeake Bch.,MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 21. Signature of Funeral Service Licensee Glady a. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 200 water Physician al turi /Medical Due to (or as a consequence of): **Examiner** surriema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes ZNO ed by the a 9 Unknown 9 I Inknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No 200 24b. Were autopsy findings available prior to completion of cause of death? mall 24a. Was an autopsy performed? has certificate 1 Yes 1 ☐ Yes 2 ☐ No 28 No or Attending Physicien: ours after death.

nerel Director: After this certifica
filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manner of Death Injury a DNatural 5 Pending 1 🖺 Yes 2 🗀 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Hospital within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) Fo the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier erbert 433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 odical + Kerry

State Registrar

31. Date filed (Month, Day

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State State Registra AMEND#23aIIperMD4/5/07, EWW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 31, **Physician** 2007 11:50 PM March **JOHN** HOWARD HUBBELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) April 9, 1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 1**⊠**M 2□F Months Days Hours Michigan 81 365-22-1835 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other transments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Md. Montgomery Gaithersburg Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20877 514 Russell Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No White Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Radiation Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Lipe Howard Adams Hubbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, Md. 20877 Jean N. Hubbell (Wife) 514 Russell Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition April 5 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metropolitan Crem. Alexandria, Va. 5 Other (Specify) 2007 4□Donation 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home urtis Md. 20877 10 East Deer Park Dr. Gaithersburg, 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner 10 Hours Pneumonia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner 10 Years Chronic Obstructive Pulmonary Disease law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): 68760, attending physician Box (IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown ins been signed by the 2 should be detached ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by Records, 1 X Yes 2 No 3 Probably 4 Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an VTI Urinary Track Infection autopsy performed? Yes 2**X**1No certificate has page 1□ Yes Vital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA ို ō funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Μ within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature April 2, 2007 48160

State Registrar

11:50 pm

JOHN

WBBFLL

31. Date filed (Month, Day, Year) APR 0 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#16aperFH4/4/07,BMW,McCo Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 05:45 AM 2007 MARGARET MAR CH 3-1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 4, 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Maryland 1 M 2 F 73 217-32-2010 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State "natural", or items 23a or 28a-f show to a fear and a fear a must be notified at 1 XYes 2 No Rockville Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 U.S.A. 811 Westmore Avenue Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Maryland 21215-0036 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired)
NUTSING ACCIONATE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Me ical Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Rockville Nursing Hm Assistant yr other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Cora V. Baker Robert S. King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1204 Knoll Mist Ln, Gaithersburg, MD 20879 Shelley Johnson (Daughter) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Acoln Park Cem Rockville, MD 4/9/07 4 □ Dogation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure Po not enter the mode of dying, such as cardiac or respiratory arrest, e, or complications that caused the death List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Concer /Medical Due to (or as a nsequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To Be Certification:

Division or Vital Records, P.O. Box 68760

		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ TNo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (0	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1,⊠thpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	(Month, Day Year) Injury Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. I at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

00060168

Moreh 31,2007

ROCKUITE, M.S.

30. Name and address of her on who completed cause of death (Item 23a) (Type, Print) 1201 SEVEN LOUIS Road Swite 111 ASEFA MEKOWNEN

State Registrar

Medical

31. Date filed (Month, Day, Year) 2007 APR 04



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Harris 2007 1:55 A M March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 31,1922 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days 1**★** M 2□ F 217-20-4377 84 Charlotte, NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No D.C. Washington Director None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 R Street, N.E. 20002-2118 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Twes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1946 1 ☐ Yes 2 🛣 No Specify: Black Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Department Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lela Parker John Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 R Street, N.E., Washington, D.C. 20002-2118 Isabelle L. Harris - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Quantico Nat'l Cemetery 04/03/07 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee Mullians 3831 Georgia Ave., NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPSI

Due to (or as a consequence of) disease or condition resulting in death) NEU MONIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown RENAL TNSUFFICIENCY CHRONIC Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an HYPERTENSION pertorm EFOF20 / Yes 2 26. Place of Death (Check only one) CARDIOMYOPATHY WITH 25. Was case referred to predical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Division or Vital Records, P.O. Box 68760

The law requires that the death certificate be executed and burial-tran attending physician for use as the buria ed by the a been signed to should be deta To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

Physician

/Medical

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, tt

Physician

/Medical

Saltimore, Maryland 21215-0036

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JCH/BHOTL

2007

Pay, Year)

SUITE B 1BBA aistrar's Signature

HANOVER 720 GREENBEL

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

I Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Division or Vital Records, To the Hospital or Attending Physician:

23d. Date of delivery Dav 23e. Did tobacoe use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manus of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 120058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medal Confor Annapolis MD MD Druckrundel JARZO OUNCE 32. Registra Signature 31. Date filed (Month, Day State APR 0 6 2007 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

9:15 A M

Birthplace (State or Foreign Country)

white

Bilodeau

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Registrar

Certificate of Death

4b. City, Town, or Location of Death

Huntingtown

2. Date of Death

April 1, Day 2007

4c. County of Death

Calvert.

Black, White, etc.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No

Year

Month

White

Specify:

6:40 PM

9. Birthplace (State or Foreign Country)
Wash. D.C.

10d. Inside City Limits

1 □Yes Ž∏No

Francis Hughes

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and the of certifier

Peter Wisniewski, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

D40370

110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

1. Decedent's Name (First, Middle, Last)

Charles

4a. Facility Name (If not institution, give street and number)

1291 Matthew Drive

Physician /Medical Examiner

State of Maryland / Department of Health and Mental Hygiene) 1 - Stete Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** April 8:57 a Mae Morrison Hornberger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 255 Woods Way Elkton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 ☐ M 2 🖸 F 216-20-0585 80 1926 1, Director May Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar pages. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 Woods Way 21921 U.S.A. Completed by Funera 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry State of Maryland 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hatem Toll Bridge Facility College (1-4or 5+) Superintendent of Transportation Perryville, Maryland Twelve Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Phillip Sherdan Morrison Sadie Linton ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellis D. Hornberger (Husband) 255 Woods Way, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham Cemetery 04/11/07 Colora, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral H Home, P.A. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final congrative Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 19-BS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the ettending physicien end deteched for use as the burial-transit The law requires that the death certificate be executed farobid that initiated events resulting in death) Last Due to (or as sequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown is been signed by the 2 should be deteche 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Osterporo Sis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RS certificate 2 No 1 Yes 2 🔀 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5% Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1. Natural 5 Pending 1 ☐Yes 2 ☐ No death. investigation 2 Accident filled in by the Director 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACHder 322 10 Cec. NONTH EAST 32. Registrar's Signature 31. Date filed (Month, Day, APR State Registrar

R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 April 6:45 A M Russell W. Harper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 10101 Governor Warfield Parkway#324 Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □XM 2 □ 215 28 1462 74 July 15, 1932 Maryland Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □Yes 2 No ns 23a or 28a-f sh must be notified Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 10101 Governor Warfield Parkway #324 21044 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. traumatic event, the Medical Examiner Armed Forces? 1. Mayes 2 □ No 1950 — If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of National Sales Maryland Cup Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, h and Mental h Be Russell B. Harper Rena Grubb ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #32419a, Informant's Name/Relationship (Type, Print) item 27 i 10101 Governor Warfield Parkway Columbia, MD 21044 Ellen Harper/Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o Metro Crematory 4-7-2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Saylorna Immediate Cause (Final disease or condition resulting in death) Q1 **Physician** /Medical Du-lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (r as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (pr as a consequence of : Division or Vital Records, P.O. Box 68760, physician Physician/Medical the. as IF FEMALE: for use yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy perform certificate 2 **N**O 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 【▼Residence 6 ☐ Other (Specify) 1 ☐ Yes 3€ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

9+1 State

Date filed (Month, Day, Year) **APR 0 9** 200 Registrar

30. Name and address of Ferson who co

29b. Signature and title of certifier

Del C

29d. Date signed (Month, Day, Year)

April 6,

2 a) (Type, Print

29c. License number

State Registrar

filled in by

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lat

Ca.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

		_	1 = For State Registrar AMEND#290perM		MbCo	•	rtificate of				Reg. No.	2007	12819		
	Physicia	an	1. Decedent's Name (First, Middle, La	ist)						2. Date of De Month	Day	Year	3. Time of Death		
	/Medic		Esther Lutsky							Apri1			8:48 a ^M		
)	Éxamin	er	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town,					County of Death			
	%· 	4	Casey House 5. Social Security Number 6. 9	Sex 7. Age	e (In yrs. las	et hirthday)	If Under 1 Yea	ockvil r If Und	1e er 24 Hrs.	8. Date of Birt		lontgomer	y nplace (State or Foreign		
	Funeral Director		120-03-3399	1 ☐ M 2 🕱 F	86	Yrs.	Months Day			(Month, Da August 2	y, Year)	Cot	klyn, New York		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits		
	Maryl f sho led al	ō	Maryland Montgome	rv			Si	lver S	nring				1 ∐Yes 2K No		
	the 1 28a- notif	Directo	10e. Street and Number	,			10f. Zip Code		hr rug		10g. Citize	en of What Co	untry?		
	3a or		3330 N. Leisure World	1 B1vd #405			2	0906				U.S.A.			
	deati ms 2 r mu	Funeral	11. Marital Status	12. Was Decedent 1 Armed Forces?	Ever in U.S.	13. \	Was Decedent of f Yes, specify Cu		Origin? (Sp	ecify Yes or No	- 1	4. Race - Amer Black, White			
350	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	1 Tyes 2 X N If Yes, Give Year or Dates:	No		1 ☐ Yes 2KL N			1110411, 010.7		Specify:	White		
215-0036	2 hot	ted	15. Decedent's E	ducation	I	16a. Deced	dent's Usual Occ kind of work don	upation	ant of work	ina	16b. Kin	d of Business/I	ndustry		
7	e. an "n Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT use reti	red)	USI OI WUIK	iriy					
7	ed wil	Son	12			Se	cretary	1				r Depart	ment		
/land	be filed that Hygie of other event, the	a	17. Father's Name (First, Middle, Las					18. Mo		e (First, Middle,	Maiden S	Surname)			
_	should I and Men s marker umatic	은	Solomon Luts			401 14 111	/0/			e Garbus		T 0			
Mar	C) 10 = 18		19a. Informant's Name/Relationship				ng Address (Stre				-		up Code)		
ď	s 1 and f Health item 27 other tr		Leonard Jewler - Son 20a. Method of Disposition	1	20b. Pla		orthingto sition (Name of matory or other p			Date Date		ation - City or	Town, State		
Baitimore,	permit. Pages 1 Department of I Important: If ite any injury or ot once.		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	-	-	natory or other p Cemetery		4/5/20	007		phi, Mar				
gal	permit. Depart Import any inj	9	21. Signature of Funeral Service Lice	cility neral l ire Ave	Home, Inc	ver Sp	oring, Ma	ryland 20904							
			23a. Part1. Enter the disease, or con shock, or heart failure. List only			0,	Approximate Interval Between								
	Physician	Immediate Cause (Final disease or condition Myelodysplastic Syndrome										Onset and Death			
j.	/Medical		resulting in death)	Due to (or as			narome								
	Examiner		Sequentially list conditions	b											
10	D #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):									
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ance of):									
Š,	tificate be executed g physician and as the burial-transit			Due 10 (01 a3	a conseque	.1100 017.									
68/60 ,	icate phys s the	edical		_d											
O. BOX	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3□	∃Ectopic pregnar ∃Other <i>(specify)</i>				23	3d. Date of deli Month	ivery Day Year		
,	that ned by detail	y Ph	Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying cause	given in Pa	rt I.	23e. Did t	obacco us	e contribute to	the cause of death?		
S	w requires that s been signed t should be det	d by								10	Yes 2	No 3□Pr	obably 4 Unknown		
Hecords	s b	Completed								24a. Was	psy	prior to o	topsy findings available completion of cause of		
										1□ Yes	rmed? 2 No	death? 1 ☐ Yes	2□ No		
VItal	slcian certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		=/0		ther.		th (Check only o			Uospiss		
Ö	his I d	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ry 2	H/Outpatier 28b. Time of	IL 3 DOA	4 🗆	Nursing Ho	ome 5 ☐ Resi 28d. Describe			cify) Hospice		
0	ding h. : Afte fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury		/orƙ? □ Yes 2	□No						
DIVISION	al or Attending Physician: after death. I Director: After this certific d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	20e. Place of inj	ury - At hom c. <i>(Specify)</i>		eet, factory, offic	e			(Street and Number or Rural Route Number, wn, State)				
	urs era			hysician: To the best	f examination										
	To the Hosp within 24 ho To the Fune completely f	Medical	29b. Signature and title of certifier	and manner st	ated.		29c. Lice	nse numbe	er		29d. Date	signed (Monti	h-Deyn Year)		
)	10		Rynikia Y.	n Dull	am	so DO	Ha	058	032		Apri	Epril	2007		
	()		30. Name and address of person who	s, D.O., 6001	Muncas	ster Mi	.11 Road,	Rockvi	11e, M	aryland 2	0855				
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4	2007 32. gistr	ar's Signatu	K A	borte								

DHMH 17 Rev 1/2001

			Pleas										Copies		_	le.		
			For State Registrar		State	of Ma	arylan	-			lealth a <i>Death</i>		ental Hy		0.0	y prog me		0.00
			Registrar 1. Decedent's Name (First, Middle)	, Last)					runca	ie oi	Deaui		2. Date of D	Reg. N	0.		3. Time	of Death
Physi /Me			Jacqueline Anne	tte	James	3							Month April	1,	^{ay} 2007	Year	2:11	. P ^M
Exam			4a. Facility Name (If not institution	, give str	eet and n	umber)			4b. City		r Location o	of Death			c. County o			
			Southern Maryla: 5. Social Security Number	nd H	ospit		o (In um	last birthda	a) If I Inde	Cli:	nton If Under:	24 Hrs	8. Date of B		Princ			
Funera Directo	_		220-90-9031		W 2⊠ F	7. Ag	45 45	Yrs.	Months		Hours	Min.	Jan. 1	ay, Yea	962	9. Birthp Coun Mary	lace (Stat Land	e o <i>r Foreign</i>
D			Usual Residence of Decedent															
faryla shov ed at		5	10a. State 10b. County Marvland Fred		1_			y, Town or l								1		City Limits es 2 ☐ No
the Nr. 28a-		Director	Maryland Fred 10e. Street and Number	eric	K		rı	ederi		p Code				10g. C	itizen of W	hat Coun	try?	
th with 23a o sst be			999 Heather Rid	ge D	r., l	Jnit	: L			2170	2			Un	ited	Stat	es	
er dea tems		runerai	11. Marital Status	12	2. Was De Armed F	cedent orces?	Ever in U.	S. 13	. Was Dec	edent of F	lispanic Ori an, Mexicar	gin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	0-	14. Race Black	- Americ , White,		
rs after the xamilians and xam		Dy L	1 Mever Married 2 Marri 3 Widowed 4 Divorced	ed	1 ∐Yes If Yes, G Year or I	2 ½ [1 live Dates:	No		1 ☐ Yes	2 ⊠ No	Specify:				Specify:	Bla	ck	
72 hou natura		led	15. Decedent (Specify only highes	s Educa	tion			16a. Dec	edent's Us	ual Occup	oation	t of working	20	16b.	l Kind of Bus	iness/Inc	lustry	
vithin within han "han "		Сотрыетеа	Elementary/Secondary (0-12)	- grade (College		5+)				during mos d)		ig		1.1			
filed v Hygie Afher t			12 17. Father's Name (<i>First, Middle, i</i>	Last)				Cert	111ed	Nur	se's A		(First, Middle		ealth on Surname	_	e	
id be fental rked c	9	10 De	William H. L.	Jame	S						Gei	raldi	ne Hoy	7e		,		
2 shot and N ls ma			19a. Informant's Name/Relationsh		,								l Route Num					1700
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infinoratist if them 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at			Geraldine James 20a. Method of Disposition	/ M	othei	<u> </u>	20h P						Unit I					.1702
ages ant of H t: If ite			1 ☐ Burial 2 X Cremation		noval fron	State		lace of Dispendery, cr			,~~	pril	6,		Location - (-		
permit. F Departme Importan any injur	oj.	ł	4 Donation 5 Other (Specify) Resthaven Crematory 2007 Frederick, Maryla 21. Signature of Tuperal Service Licensee 22. Name and Address of Facility 21. Course and Color B. A.															
	ouce		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701)1		
			23a. P.//11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail to List only one cause on each line. Approximate Interval Between														Between	
Physicia: /Medica			Immediate Cause (Final disease or condition resulting in death)	a.	H de	44	hun	LCCL .								_		
Examine	er			1 h	. 00	1341	lio	nui	pal	hy								
sit sd	2	20	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J "	Due to	o (or as	a consequ	uence of:		1								
be executed ician and burial-transit	5	Examilie	Cause (Disease or injury that initiated events resulting in death) Last	С.	Due to	o (or as	a consequ	uence of):								_		
eath certificate be executed attending physician and for use as the burial-transit				L _{d.}				,										
The law requires that the death certificate the has been signed by the attending physing 2 should be detached for use as the	Mod	riiysiciali/meulcal	IF FEMALE:	200														
ath ce attendi	Juci	la l	23b. Was decedent pregnant in the past 12 months?	230		birth	pf pregna 2 ☐ Fetal time of de	I death 3	□Ectopic		у				23d. Date Mon		ry Day	Year
the de	1000	1331	1 ☐ Yes 2 🕱 No 9 ☐ Unknown		9□Unki		time or u	ealii 5	Other (s	pecily) _								
ires that the de signed by the		2	Part II. Other significant condition	ns contr	ibuting to	death b	ut not resu	ulting in the	underlying	cause giv	en in Part I.		23e. Did	tobacco	use contril	oute to th	e cause o	f death?
w require been si should t													1	Yes	2 □ No :	B ☐ Prob	ably 47	Unknown
ne law has b ye 2 sl	200	naiaidiiioa											24a. Wa	opsv	ng	ere auto ior to cor eath?	osy finding npletion o	s available cause of
			25. Was case referred to medical								26 Diago	of Dooth	1□ Yes (Check only	2 X N	lo 1		2□ No	
nysicia nis cert direct	To Bo		examiner? 1 ☐ Yes 2 No	Ho	spital: 1	(Inpatie	ent 2	ER/Outpation	ent 3 □ D	OA Oth	or:		ne 5 Res		6 □Othe	(Specify	<i>'</i>)	
ing Pr			27. Manner of Death 1 Natural 5 □ Pending		28a. Date (Mo.	of Inju	ry y Ye <i>ar</i>)	28b. Time Injury		28c. Inju	ry at rk?	2	8d. Describe				,	
ttend death. ctor: /	1	Sal	2 Accident investig 3 Suicide 6 Could n	ot be	28e Plac	e of init	ırv - At ho	me, farm, s	treet facto		Yes 2□I		8f. Location	(Stroot o	and Numbe	r or Pura	I Poute M	mhor
al or A safter il Dire	Cortification:		4 ☐ Homicide determi	nea	build	ding, etc	c. (Specify	()	., , , , , , , , , , , , , , , , , , ,	, ooo			City or To	own, Sta	te)	Oi nuia	TIOBIE IVI	arribei,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Modical		29a. Certifier (Check only one) Certifyin 2 Medical I	g Physic Examine	r: On the	basis of	f examina	wledge, deation and/or	ath occurre	at the ti	me, date an opinion, dea	nd place, a ath occurre	and due to the	e cause(e, date a	s) and man	ner as st	ated. the caus	e(s)
To the vithin 2 To the complet	Mo	2	29b. Signature and title of certifier	**	1		10.00		29	c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)
			> Varsher L	bu	ikei	\wedge	m)	Ţ,	264	+28	39		04	410	2/0	7	
2			30. Name and address of person v	0.	pleted cau	ise of de	eath (Item	23a) (Type	Print)	RAF	-651	PA	Clir	110	n no	20	200	725
S	State		31. Date filed (Month Pap Year)	9 20	AR /	Redistra	ar's Signa	ture L	JUN	1 10		· ·	<u> </u>	110	111/	100	NU	(3)
Regis			me et 0	J 20	01	P. Cal	ME	D.	goard	and and								

To the Hospital or Attending Physician: Division after death.

within 24 hours a To the Funeral I

State Registrar

Medical

RICHARD INTHICUM. M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204

and manner stated

in

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 6 2007

determined

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

2245

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

W

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

D31826

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1 _ State	and / Department of Health and N	Mental Hygie	ne 2007 1000
	4		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No (U U
	Physici			-Gonder	Month	Day Year 3:15P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death
			Country Companions	Taneytown		Carroll
	Funeral		1 DM 2 X F	yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)
2	Director		220-26-0016 76 Usual Residence of Decedent	Yrs.		1930 Maryland
	yland sow at			. City, Town or Location		10d. Inside City Limits
	e Mar a-fst iffied	ctor	Maryland Carroll	Union Bridge		1 □Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a	eral	418 McKinstry Mill Rd.	21791		U.S.A.
	ter de item iner n	Funeral	11. Marital Status 1 Never Married 2 Married 1 1 Yes 2 No	n U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs af al', or Exam	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ X No Specify:		Specify: White
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notifiled at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b	. Kind of Business/Industry
121	s 1 and 2 should be filed within 72 hc if Health and Mental Hygjene. Item 27 is marked other than "naturi other traumatic event, the Medical	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
d 2	filled \ Hygie		1 1 17. Father's Name (First, Middle, Last)	postmaster 18 Mother's Name	Fe e (First, Middle, Maid	deral government
an	2 should be far and Mental His marked ot raumatic ever	To Be	David John Roop		ssie Gordo	**
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rur		
	f and 2 Health a em 27 is		Douglas M. Keefer/ son	750 Hess Ct. Westmin	nster, MD	21157
ore	9 = 5		20a. Method of Disposition 20 1 [XBurial 2 □ Cremation 3 □ Removal from State 20			Location - City or Town, State
Baltimore,	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Specify)	eadow Branch Cem. 4/17	/2007 We	stminster, MD
Bal	permit. Pag Department Important: any injury o		21. Signatur of Foreral Service Licensee	22. Name and Address of FacilityHart	tzler Fune	ral Home
TG :	2.8		23a. Part1. Enter the disease, or complications that caused the complications the complications that caused the complications the complications the complications the complications the complications the complications that caused the complications the complication that caused the complications the complication that caused the complications the complication that caused the complication the complication the complication that caused the complication the complication the complication that caused the complication the complication that caused the complication the complication that caused the complication the complication that caused the complication the complication that caused the complication the complication that ca	310 Church St.	New Winds or respiratory arrest.	or, MD 21776 Approximate
	Physician		shock, or heart failure. List only one cause on each line.			Interval Between
J.	/Medical		disease or condition resulting in death) a. Due to (or as a con	sequence of):	n(Lave
E	Examiner		Sequentially list conditions. b. ditlen	rasculur accede sequence of): oscleratu Varento	Lese	ne 2m
5	ped lisit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):		0
_	cate be executed ohysician and the burial-transit	xan	that initiated events resulting in death) Last C	sequence of):		
8760,	re be (dical E	L _d			
9	rtifica ng ph as th	Medi	IF FEMALE:			
Box	requires that the death certifica een signed by the attending pl nould be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pre	gnancy etal death 3 □Ectopic pregnancy		23d. Date of delivery
0	he de the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5 Other (specify)		Month Day Year
<u>α</u>	res that the de signed by the a be detached		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	quires n sign uld be	d by			1 ☐ Yes	2 □ ♠o 3 □ Probably 4 □ Unknown
Vital Records,	aw is b	Completed			24a. Was an	24b. Were autopsy findings available
ž	The law sate has b page 2 st	mo;			autopsy performed1 1 Yes 2 🔼	prior to completion of cause of death?
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	assulie
<u>_</u>	ys Sis	유				6 Other (Specify) Juny
- Lo	ding I	ijon:	27. Manner of Death 1) injury vvork?	28d. Describe how in	jury occurred
Division or	Attending r death. ector: After by the funer	ficat	3 Suicide 6 Could not be 28e, Place of injury - A	t home, farm, street, factory, office	28f Location (Street	and Number or Rural Route Number,
ă	al or a after al Direct	Certification:	4 ☐ Homicide determined building, etc. (Sp	ecify)	City or Town, Sta	ate)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier (Check only (C	knowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occur	and due to the cause	(s) and manner as stated.
	the h	Medical	one) and manner stated. 29b. Signature and title of certifier			
	M. Wil		29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
		-	30. Name and address of passon who completed cause of death (I	tem 23a) (Type, Print)	77 4	T/16/2007
	10		Jahren haldlehn les	28 Poolo & d. las Later	incher	m 0 1 1 = 1
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	1000	1
	Registra		APR 2 0 2007 Jenem	& Speeds		
DHM	/IH 17 Rev 1/20	01	7-4-4-	ORIGINAL		
				ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #27, perME, 988, 6/18/0/ TT State of Maryland / Department of Health and Mental Hygiene? 12823 1- State Registrar AMEND#17perINF4/12/07, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $31^{\text{Day}}, 2007^{\text{ear}}$ Larry March J. Kling 11:22A. M 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital Center 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 29, 1943 5. Social Security Number 6. Sex 14∑ M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Washington, DC 217-42-1864 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Greenbelt Yes 2 No 10f. Zip Code 20770 10e. Street and Number 10g. Citizen of What Country?
United States 7742 Lakecrest Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donbar Snyder Kling Don Bar Gilda Bonuccelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Kling -sister 4104 Kenny Street Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/4/2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V: Borgwardt Funeral Home, PA Donald 0.19 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nematoria disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Feb. 18, 2007 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 3:00P M 5 Pendina 1 ☐ Yes 2 No investigation fall on floor 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide building, etc. (Spe At Home

Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 atter for u page 2 should be detached Division of Vital Records, or Attending Physician: After this certific funeral director, within 24 hours after death.

To the Funeral Director: filled in by the

Physician

/Medical

Examine Physician/Medical Completed by Be Certification; To

Physician

/Medical

Examiner

Director

Funeral

Š

Completed

Be

۵

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itame 23a or 28a-f show any figury or other traumatic event, Tra Madical Examinal must be notified at once.

Baltimore, Maryland 21215-0036

Medical

29a. Certifier

4 Homicide

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 7742 Lakecrest Dr. Greenbelt, Md. 20770 1 Certisting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Indical Examiner: On the basis of examination and/or investigation, in my opinion, seathoccurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and itle of certifier

29c. License number 755020

herery US 20785

29d. Date signed (Month, Day, Year) 4-3-07

who completed cause of death (Item 23a) (Type, Print) HOSPITAL Drive 3001

31. Date filed (Month, Day, Year) APR 06 Registrar

egistrar's Signature

To the Hospital

10

			For State Registrar		f Marylar		artmen rtificate			and M		Reg. No. 2	007	12	82
	Physic	ian	Decedent's Name (First, Middle								2. Date of Dea		Year	3. Time	
	/Medi			uth		irschbau					April 4,			8:53	р м
	Examir	ner	4a. Facility Name (If not institution 4419 Brookfield	_	nber)		,			April 4, 2007 April 4, 2007 8:53 1					
hate	A Company of the Company		5. Social Security Number	G. Sex	7. Age (In yrs.	last hirthday)	Kens:	.,		24 Hrs.	8 Date of Birt			-	or Foreign
и	Funeral Director		350-20-9298	1 □ M 2 K F	77	Yrs.	Months	Days	Hours		(Month, Daj	/, Year)	Cou	ntry)	
400	provide delega		Usual Residence of Decedent								oury 19,	1929		<u> </u>	IIOTS
	ylanc Jow at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
	the Marylar 28a-f show notified at	cto	Maryland	Montgomery		Ke	nsingt	m						1 □ Ye	s 2 🗙 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	23a ust b	rall	4419 Brookfield	Drive				2089	5				USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Mari 3 □ Widowed 4 □ Divorced	ied Armed Fo	2x∑ No ve		Was Deced If Yes, spec 1 □ Yes 2		ispanic Ori un, Mexicar Specify:		ecify Yes or No- Rican, etc.)	В	lack, White,		
Ö	72 ho	Completed	15. Deceden (Specify only highe	t's Education		16a. Dece	dent's Usua	l Occupa	ation	t of work	ina	16b. Kind of	Business/In	dustry	
21	thin 7 e. an "r Med	Jple	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT us	e retired))	t or work	ing				
	filed wi Hygien Sther th	S	12			Home	maker								
nd	be file tal H d oth	Be	17. Father's Name (First, Middle,									Maiden Surn	ame)		
<u>V</u>	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	ဥ	Bernard T. Kenne						-						
Maryland	2 sh and is m		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailii	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	r, City or Tow	ın, State, Zip	Code)	
Baltimore, I	Pages 1 and 2 nent of Health int: If item 27 i	Michael E. Kirschbaum/ Husband 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemeter), crematory or other place) April 9,												•	
ij	그 두 약 즉		Da. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State											Maryla	nd
Ba	permi Depar Impor any Ir once.		1 Abillion	IB									D 20001		
Physician / Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded in the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of the Pancreas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													Approxim Interval B Onset and	etween d Death	
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical Examiner	gause. Enter Underlying Cause (Lusease on II)ury that initiated events resulting in death) Last	c	Due to (or as a consequence of):										
P.O. Box (res that the death certific signed by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		oirth 2 Feta nant at time of c	aldeath 3□	Ectopic pro					I		-	Year
	ss tha gned l	by P	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of	death?
ord	w requir been si should b		Asthma, Athritis, I	Diverticulit	is,Hyper]	Lipidemi	a				1 🗆 Y	es 2🎦 No	3 ☐ Prol	bably 4	Unknown
Vital Records,	: The law r cate has be , page 2 sh	Completed									24a. Was autop perfor	sy med?	death?	ppsy finding impletion of 2 No	s available cause of
Vit	ysiclan; Th iis certificate director, paq	Be	25. Was case referred to medica examiner?	Hospital:	-			Othe		of Deatl	h Check onl o	пе			
ō	Phys this	은	1 Yes 2 No 27. Manner of Death	28a. Date	npatient 2	ER/Outpatier 28b. Time o		Α	4 ∟ Nu		me 5X Resid			fy)	
no	ding Pt h. After th funeral	lion	1 XXNatural 5 ☐ Pendin	g (Mon	th, Day Year)	Injury	м	Bc. Injury Work	′ເ?ົົ Yes 2 ∐ I		Zou. Describe i	ow mjury occ	urred		
Division	ial or Attending s after death. al Director; After ed in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	not be 28e. Place	of injury - At heng, etc. (Special	l ome, farm, str fy)					28f. Location (S City or Tow	treet and Nur n, State)	mber or Rura	al Route Nu	ımber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical one)		best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation,	in my o	pinion, dea	nd place, oth occur	red at the time,	date and plac	e, and due t	o the cause	
	J with Source	Σ	29b. Signature and title of certifie	S Sta	cole	, pes	290		27301			29d. Date sigi April	ned (Month, L 5, 20		
	Sta	oto.	30. Name and address of person Douglds Shum 31. Date filed (Month, Day, Year)	raker, N.	ND 615	W. M	ontq	ome	ry F	tve	me, R	ockvii	IL. M	D 209	850
4	Registi	_	APR 06	2007	egistrar's Signa	5. Ap	wei -								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** KROMPART DONALD 04 Η. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ional medical Centre WICOMICO 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under **Funeral** Days Hours Min. 1X M 2 F 76 133-24-7369 Sept.27,1930 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Ocean Pines 1 □Yes 2 X No Worchester MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 Unites States 1044 Ocean Parkway Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give • Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: White <u></u> **'**55-57 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Int: If item 27 is marked other than Lutheran Minister Theology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leland Krompart Lucia Rynalski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau 1044 Ocean Parkway, Ocean Pines, MD 21811 Nancy L. Krompart/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Junior Order Cemetery 04/07/07 Preston, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Framptom Funeral Home, 218 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YO WARDIAL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

Donald

SALISBURY MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chodnicki

400 E SHORE DRIVE

\geq	
the	
with	
death	
after	
hours	
72	
within	ene.
filed	nent of Health and Mental Hygiene.
pe	ntai
PIN	Mei
sho	Ы
2	ha
and	alt
-	Ĭ
jes	ō
Pag	nent
	Pages 1 and 2 should be filed within 72 hours after death with the M

physician and the burial-transit death certificate be executed Division or Vital Records, P.O. Box 68760 as attending p ed by the a ate has been signed by page 2 should be detacl

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1130 A Wanda 7007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
May 26, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F 92 190-34-7895 Germany Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County Department of Health and Mental Hygiene. mportant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Prince George's Berwyn Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 58th Avenue 20740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No if Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 🕱 No Specify. þ if Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Business Seamstress / Designer 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilie Gerke Eduard Dreger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 58th Avenue, Berwyn Heights, MD 20740 Rudolf Kampia - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 4/9/2007 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Millia. 23a. art1. Enter the disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Adenocaremona 100V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 | Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 1 Yes 2**5**No 3 DOA ပ 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7007 123757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z. Rell ME Mais MD APR 0 9 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician Pauline D M Frances Kinnaman April 2007 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Waldorf Center Waldorf Charles 8. Date of Birth (Month, Day, Year)
Nov. 28, 1921 Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗙 F 579-28-9024 85 Director Usual Residence of Decedent 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4140 Old Washington Road 20602 USA by Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify White Specify: er than "natural", o 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Harvey Thorne Ida Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Richardson - Daughter 15240 Deborah Drive, Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Washington Nat'l Cem. 4-11-2007 |Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service tricensee 22. Name and Address of Facility M01391 3035 Old Washington Rd. Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 ☐ Other (specify) P.O. I ed by the a 1 Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown TOTHRIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed' certificate 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Monne Death 1 3 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation il or Attendir after death. I Director: Af d in by the fui 1 🔲 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and little of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

102 PAUL MELION CT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09

ASHVINKUMAR

				State of Ma	arylar		epartment of Certificate of		Mental Hy	giene	07	12828
		5	1. Decedent's Name (First, Middle, Las	st)					2. Date of De	eth		3. Time of Death
	Physicia		Charles Edward	To: more	~~	Too			Month Mozarlo 2	Day	Year	0.55
	/Medic		4e Fecility Neme (If not institution, give	Lawren	ce,	U.F.		4b. City, Town, or	March 3		of Death	8:55 p.m.
4.7	Examin	er						•				
			Montgomery General Ho	~			day) If Under 1 Year	Olney If Under 24 Hrs	7		gomery	
ı	Füneral Director		215-05-2850	ex 7. Age □XM 2□ F 88	e (In yrs.	lest birth Yı	Months Days				9. Birthp Cour Ohio	place (State or Foreign ntry)
	D .	-	Usuel Residence of Decedent 10a. State 10b. County		100 Cit	Tour	or Location			-		10d. Inside City Limits
	aryte	-	Tob. County		100. 010	ly, rown	or Education				'	1 ☐ Yes 2 ☐,No
	Ba-f	8	Maryland Montgomery	7		R	ockville					10163 20210
	er t	훒	10e. Street end Number				10f. Zip Code			10g. Citizen of \	What Cour	ntry?
	15 W	Funeral Director	14504 Faraday Drive				20853	3		USA		
	dea Fig	ē	11. Marital Status	12. Was Decedent 8	ver in U	,S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specify Yes or N	o- 14. Rac		can Indian,
0	after ar the	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo				nto Fican, etc.)		ck, White,	
N	urs a	۵	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2√2 No	Specify:		Specify	/ Whit	te
21215-0020	2 ho	8	15. Decedent's Edi			16a. D	ecedent's Usual Occu	pation		16b. Kind of B	usine <i>s</i> s/In	dustry
7	7 0		(Specify only highest grad			9	Give kind of work done ife. DO NOT use retire	e during most of wo	orking			
	the ene	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	P	roject Manage	ar			onstru	action
	Hyg Hyg ther ant,	Be Completed by	17. Father's Name (First, Middle, Last)				rojece range	1	me (First, Middle	, Maiden Surnan		acciai
an	od be	o B	Charles Edward Lawre	mce							,	
Maryland	s 1 end 2 should be filed within 72 hours after death with the Marylend if Health end Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, it a Medical Examiner must be notified at	₽∤				1		, ,	e Marlin			
<u>8</u>	2 st is n reur		19a. Informant's Name/Relationship (T	ype, Print)		196. 8	Mailing Address (Stree	at and Number or H	urai Houte Numb	er, City or Town,	State, Zip	Code)
	end ealth n 27		Margaret Lee Lawrence/	Wife		1450	04 Faraday Dr	rive, Rocky				
2	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Domoval from State	20b. F	Place of E cemetery,	Disposition (Name of crematory or other pla	ace)	Date	20c. Location -	City or To	own, State
Ĕ	Peges nent of int: If its iry or o		4 Donation 5 Other (Specify,		Parl	klawn	Memorial Pa	rk	April 6 2007	Rockvill	o Mar	arl and
Baitimore,	permit. Peges Depertment of Important: If it any injury or o	-	21. Signature of Fameral Service Licens	see			22. Name and Addr Francis J	ess of Facility			s, Mai	y Land
ñ	Dep Per	- 1		000	,							
		\perp	Mohen	Tok			500 Universi				D 2090	
~4			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each lin	the deat e.	h. Do no	t enter the mode of dy	ing, such as cardia	c or respiratory a	irrest,	1	Approximate Interval Between
	Physician										1	Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition	, Ruptured	Abdar	ninal	Aortic Aneur	ysm			1	2 Hours
			resulting in death)	4 .	Due to (o	rasa co	nsequence of):			-		
	T #	<u>e</u>		, Aortic Ar	n (2) 17*579	≃m						9 Years
	death certificete be executed e attending physician end ed for use es the buriel-transit	Examiner	Sequentially list conditions.	0.			nsequence of):					J Tears
'n	an el	ŭ	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Atherosci	eret:	ic Car	rdiovascular	Di gongo			1	
8/60,	sicia b bu	E C	that initiated events	V			nsequence of):	DISEase			-	
ğ	ficet phy s th	=	resulting in death) Last		0) 01 000	1 43 4 00	isequence oi).				Ì	
ŏ	ding se s	₹		d								
ň	attending p	ᇙ										
j	the de by the a	Physician/Med	Part II. Other significant conditione con	ntributing to death bu	t not res	ulting in t	he underlying cause gi	iven in Part I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
7.	d by		Claractic Barrell Brill	TT	c ~				10	Yee 2 2 10	3 Prol	bably 4 Unknown
ń		2	Chronic Renal Failur	e, History o	t Cer	rebrov	ascular Acci	dent,	-			
5	en s	Completed	Urethral Stricture							an autopsy ormed?	ava	ere autopsy findings ailable prior to
O S S S	lew rees be	<u>e</u>									of	mpletion of cause death?
	sician: The lew certificate has t irector, page 2 s	E							100	Yes 2 X No	1.5	∃Yes 2 No
Ū	ficet or, p		25. Was case referred to medical					00 81 (8-				
>	cent	0 26	examiner?	Hospital:	16		Ot	hor:	ath (Check only			
5	A sid	- 4	27. Manner of Death	1 Inpatier		28b. Tim	allerit SLI DOA	4 Li Nursing i		dence 6 Oth		y)
<u></u>	Attanding F er death. ector: After by the funer	5	1 Matural 5 ☐ Pending	28e. Date of tnjun (Month, Dey	Year)	Inju	ıry Wo		28d. Describe	now injury occur	eu	
VISION	tend leath lor: / the f	Sal	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No				
Ξ	l or Att efter d Directs d in by t	Certification:	4 Homicide determined	28e. Plece of Inju building, etc.	ry - At ho (Specify	ome, farm v)	n, street, factory, office		28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	al Route Number,
)	rs efter or re efter or rs efter or rs efter or rs efter or rs efter or re effect or re efter or re ef											
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of	my know	wledge, d	leath occurred et the ti or investigation, in my	ime, date and place	e, and due to the	cause(s) and ma	nner as si	tated.
	he H he F plets		one)	and manner stat	ed.			-pinion, doain occi		cate and place,	300 (0	(4450(3)
	To t To t	Σ	29b. Signature and title of certifier	(/. 0	0		29c. Licen	se number		29d. Date signe	d (Month,	Day, Yeer)
	. 7		Vool H	YOU RIMATE	2	MI	0	D21115		April 3	, 2007	1
	10		30. Name and address of person who co	ompleted caps of de	ath (Item	23e) (Ty	/pe, Print)	021113				
			Lee R. Pennington				Poad Bathes	-g- MD 200	17			

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year) APR 0 4 2007

32 negistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29, A^M 4:20 2007 Jeanette C. Mack March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 X I July 27, 1933 Washington 577-46-3232 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Director N/A Washington DC10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20009 1512 VanBuren St., N.W. U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ Year or Dates: 3 ☐ Widowed 4 ☒ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Parker James Mack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1753 Seaton St., N.W. Washington, DC 20009 DionneHolliday / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 5, 2007 Landover, MD Harmony Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licens 7400 Georgia Ave., N.W. Washington, DC nolre Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a nasequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 □ No 9 Unknown 9X Unknown signed by the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl on a Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 1. Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Marmer of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 21 rcident by the 3 ☐ Suide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Directory filled in by 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, 29b. Signature and title of certifie ို

State Registrar 30. Name and address of person who c

Day,

APR 04

2007

31. Date filed (Month,

10

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 177

		•	For State Registrar	State of Mai	ryland	•	rtment of H		Mental Hy	rgiene	07	12831
	Physicia /Medic		1. Decedent's Name (First, Middle, Las LEON /	PRD	M	11A	SKOF	F	2. Date of De Month MARC	eath	Year 2007	3. Time of Death 1 7:20 P M
	Examin		4a. Facility Name (If not institution, give Hebrew Home of		shing	ton	4b. City, Town, o	r Location of Dea ille	th		nty of Death ontgo!	
	Funeral Director		5. Social Security Number 6. S 096-12-2899			st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av, Year) 22, 1922	Cou	place (State or Foreign Intry) York
	Aaryland ehow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom			Town or Loc hesda	cation					10d. Inside City Limits ¶∏ Yes 2 ☐ No
	with the had or 28a-i	Direct	10e. Street and Number 5802 Wyngate Driv	•			10f. Zip Code 2081	7		10g. Citizen o	of What Cou	
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Madecal Examinar must be notified at	by Funerai Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 11 Yes 2 No	Army	' "	Vas Decedent of H Yes, specify Cub	dispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0- 14. R	ace - Ameri lack, White	ican Indian, , etc.
21215-0036	n 72 hours "natural",	Completed by	3 X Widowed 4 □ Divorced 15. Decedent's Ec (Specify only highest gra	de completed)		16a Deced	ent's Usual Occur		orking	16b. Kind of		
d 212	e filed within al Hygiene. I other than "vent, the Max	e Comp	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+ 5+)		nical En	gineer	me (First, Middle	Binder		ustry
Maryland	2 should be and Mental le marked o	To B	Reuben Miaskoff			19b. Mailin	g Address (Street	Dora	Solomon	per. City or Tow	vn. State. Z	ip Code)
	is 1 and 2 s of Health an item 27 le i other treu		Carol R. Miaskoff		20b. Pla	5802	Wyngate	Drive, B		-	and 20	0817
Baltimore,	it. Part rtmer rtant njury		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer	y)	1	n Davi	d Cemete	ry 4/5/				I., New York
Ba	Dermi Depe Impo eny i		Donald (.)	Stottlen	yes	10	91 Rockv	ess of Facility Sel Funer Sille Pik	e, Rocky	ville, l	Inc. Maryl	and 20852
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. CHRONI	CO	BSTI	PUCTIV	E PULHO,	NARY I	DISEAS	5E	Interval Between Onset and Death
	Examiner	e	Sequentially list conditions, if any, leading to immediate	b. ATRI Due to (or as a	Conseque		BRILL	ATIO.	N			
, 0,	death certificate be executed e attending physicien end at for use es the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	conseque	ence of):						
68760,	rtificate b ng physic es the b	Medica	IE ECNANIE.	d								
P.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	teath 3	Ectopic pregnanc Other (specify) _	у			Date of delive Month	very Day Year
	signed be de	þ	Part II. Other significant conditions of	ontributing to death but	not result	ting in the ur	nderlying cause gr	ven in Part I.	1	tobacco use co		the cause of death?
Division of Vital Records,	The ete h page	Completed							24a. Wa auto peri 1 ☐ Yes	ormed	b. Were aul prior to c death? 1 Yes	topsy findings available completion of cause of
Vite	Physician: This certificer	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 E	R/Outpatien	t 3 DOA Ot	ner I	eath <i>(Check only</i> Home 5 ☐ Res		Other (Spec	cufy)
ion o	Attending Ph r death.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Year) 2	28b. Time of Injury	28c. Inju Wo M 1	ry at rk?]Yes 2 ∐No	28d. Describe	how injury occ	:urred	
Divis	ital or Attend rs after death al Director; led in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At hom (Specify)	ne, farm, str	eet, factory, office			(Street and Nui оwп, State)	mber or Ru	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exar	niner: On the best of and manner state	examination		vestigation, in my	opinion, death occ		, date and plac	e, and due	to the cause(s)
٠.	P ∰ P 5	2	29b. Signature and title of certifier	re Do		neg		D35	436	APRIL	101,	, 2007
			30 Name and address of person who BABBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB	completed cause of de	1 M1	0.61	12/140	NTROS	5ROAL	D, Rock	PILL	E, MD 2085
	Sta Registr			107 Been	, b	1 190	uli)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Co	ertificate of D	Death		Re	g. No.	33, 1200
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Deat Month	h Day Year	3. Time of Death
Medical Exami		Ann Marie Marcellino				March 31,	2007	2028 nrs
		4a. Facility Name (if not institution, give street and number) 18413 Snowberry Way		City, Town, c Olney	or Location of Deat	1	4c. County o Montgorr	
Funeral				If Under 1 Ye	ear If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY)	9. Birthplace (State or
Director		215-64-6402		Months Da	ys Hours Mir	Nov. 5	, 1956	Foreign Aryland Country Tyland
any	H	Usual Residence of Decedent 10a. State 10b, County 10c. Ci	ity, Town or Location					10d Inside City Limits
*								1 Yes 2 X No
ne Maryland or 28a-f show fied it nec.	용	Maryland Montgomery 10e. Street and Number	Olney 1	Of, Zip Code		10	g. Citizen of Wh	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ance.	I Director	18413 Snowberry Way		208				SA
eath wit items 2 ust be n	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes,		lispanic Origin? (S an, Mexican, Puerto		14. Race White	- American Indian, Black, e, etc.
fter d	Ĭ,	3 Widowed 4 Divorced If Yes, Give Year		es 2X N	lo specify:		Specify:	White
ours a atura camin	d by	or Dates: 15. Decedent's Education (Specify only highest grade completed)			ation (Give kind of fe. DO NOT use ref		16b. Kind of Bus	siness/Industry
36 in 72 ho han "ns dical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	_	-	ervice Ma		Occupat	tional Therapy
-00; d with giene giene ther t	튅	17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, N	l Maiden Surname))
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be	Charles L. Marcellino			Mabe	l Ann Ry	land	
21. ould E d Men s mar	흔	19a. Informant's Name/Relationship (Type, Print)						n, State, Zip Code) 89102
MD d 2 sho dth and n 27 is		Charles L. Marcellino/Father						Las Vegas, NV City or Town, State
Baltimore, bernit. Pages I an Department of Hea Important: If iten		1 V Burial 2 Cromotion 2 Demousl from State	b. Place of Disposition crematory or other	place)		Date April 5,		City or Town, State
imo Page nent c		4 Donation 5 Other Specify:	arklawn M			2007		ille, Maryland
Salt ermit. nportu		21. Signature of Funeral Service Licensee			ss of Eacility Collin			
		2 Part Letter the disease or complications that caused the dea	1 500	Unive	rsity Bl	vd. W. S	ilver St	oring. MD 20901 Approximate Interval
Physician /Medical	-	a. Part I. Enter the disease, or complications that caused the deafailure. List only one cause on each line. Subarachnol				o, , , , , , , , , , , , , , , , , , ,	,,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atheros Due to (or as a consequence		rascular D	riscuse			
		Sequentially list conditions, b. Ruptured aneur		lar arte	ery			
	je	if any, leading to immediate Due to (or as a consequence		aandi ar	rocculor di	G00G0		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Caruto	vascutar ut	sease		
recuted and ransit		d						
la la	edical	UNPENDED X AMENDED, perMI	E, g868, 6/7	/07 TT				
760, ficate be g physic the bur	Σ/	IF FEMALE: 23c. If yes, outcome of pr	regnancy		Ectopic pregr	anov	23d. Date of Month	delivery Day Year
Sox 68' death certif	rsician	past 12 months? 1 Live birth 4 Pregnant at time of	f dooth	death 3 r (Specify)	Ectopic pregi	iai icy	Worth	bay (oa)
Box 687 The death certification in the attending in the ast to the second in the seco	ıysi	1 Yes 2 No 9 Unknown 9 Unknown			-estemates est			
ires that the signed by the detache	by Phy	Part II. Other significant conditions contributing to death but no	ot resulting in the unc	terlying cause	e given in Part I.			ibute to the cause of death? Probably 4 V Unknown
ls, F quires en sig uld be						24a. Was		Were autopsy findings available
cords, law requir has been s	Completed			·		autop perfo		orior to completion of cause of death?
tal Rec rian: The certificate ector, page	, 5					1 🗸 Yes	2 No 1	Yes 2 No
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient		Other Nurs		Residence 6	✓ Other: Scene
of Vid Physic er this eral dire	유	27. Manner of Death 28a. Date of Injury	28b. Time of Inju		njury at Work?		how injury occurr	
on of \nding Ph. th :: After ti	i.i.	1 Natural 5 Pending (Month, Day, Year)		1	Yes 2 No			
Division of Vital Records, rat or Attending Physician: The law requir is after death allorecors. After this certificate has been s led in by the funeral director, page 2 should I	icat	2 Accident Investigation 28e. Place of Injury - A	At home, farm, street,	factory, office	e building, etc.			er or Rural Route Number, City
Division pital or Atten ours after death eral Director: filled in by the	Certification	3 Suicide 6 Could not be determined (Specify)				or Town, S	state)	
Hos 24 h Fun rtely		29a Certifier 1 Certifying Physician: To the best of my know	/ledge, death occurre	d at the time,	date and place, ar	nd due to the caus	se(s) and manner and place, and o	r as stated. due to the cause(s)
To the Ho within 24 b To the Furcompletely	Medical	2 Medical Examiner: On the basis of examination and manner stated. 29p Signature and title of certifier	and of involugatio		nse number			ned (Month, Day, Year)
15	2	Signature and united continer			C.M.E.		April 1, 200	_
7		20 Name and address of access who considered access of death //	Item 23a\					
	1	30 Name and address of person who completed cause of death (I Laron Locke MD. Assistant Medical Examine		Street, Bal	timore, MD 21	201		
S	tate	31. Date filed (MADA:y, pa4 2007 32 gistrar's Sign		16				
Regis		APR U 4 CUUI Mallete	Dr. Com					

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral C

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

APR 04

2007

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

412107 4 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road Bethesda MD 20814 Hossein Akhondi ASI 31. Date filed (Month, Day, Year)

egistrar's Signature

0

			For State	State	of Marylan		artment of F rtificate of		Mental Hyg	A .	. 75 100	10001
			Registrar 1. Decedent's Name (First, Midd	lle Last)		Cer	lilicate of	Dealli	2. Date of Deat	eg. No.	111	3. Time of Death
	Physicia	an							Month April 4,	Day	Year	6:20am ^M
	/Medic Examin		Frances Eleano 4a. Facility Name (If not institution		number)		4b. City, Town, o	or Location of Deatl			y of Death	U.ZUalii
	LAGIIIII	٠.	531 Randolph R	oad #101	В		Silver S			Montg	gomery	,
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	, Year)	9. Birthp Coun	lace (State or Foreign ltry)
je.	Director		716-03-0974 Usual Residence of Decedent		10	7 Yrs.			Jan. 12	, 1900	Russ	sia
	land ow at		10a. State 10b. Count	у	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Many a-f sh fied a	ţċ	Maryland Mont	omerv	S	ilver	Spring					1 ☐ Yes 2K No
	th the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	itry?
	d within 72 hours after death with the Maryland jene. Itan."natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ral	531 Randolph R				20904			United		
	er deg items ner m	Funeral	11. Marital Status	Armed	ecedent Ever in U Forces? s 2 X No	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ce - Americ ick, White,	
36	ırs aft Ir, or xamil	by F	1 ☐ Never Married 2 ☐ Ma 3 🖾 Widowed 4 ☐ Divorce	If Yes.	Give Dates:		1 ☐ Yes 2 🖾 No	Specify:		Speci	^{fy:} Whi	.te
215-0036	2 hou	ted	15. Decede	nt's Education est grade complete	d)	16a. Dece	dent's Usual Occup	pation	rking	16b. Kind of I	Business/Inc	dustry
212	within 72 ene. than "nai he Medic	Completed	Elementary/Secondary (0-12)		e (1-4or 5+)			during most of word)				
2	led will lygier ther ther ther ther there	Co	12			Chief	Secreta		me (First, Middle, I			Railroad
and	l be fi ntal ⊢ ed otl	Be	17. Father's Name (First, Middle	e, Last)					cheinerma		illej	
Maryland	should be filed vind Mental Hygies marked other tumatic event, th	은	Albert Sugar 19a. Informant's Name/Relation	ship (Type, Print)		19b, Mailir	ng Address (Street		ural Route Number		n, State, Zip	Code)
Ž	and 2 sealth ar n 27 is ler trau		_	Son)					SilverSpr			
J.	- エッチ		20a. Method of Disposition	0	20b. I	Place of Dispo	sition (Name of matory or other pla	ice)		20c. Location		
altimore,	Pages ment of I ant: If ite ury or o		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)		. Leba	non Cemet	tery 4/6	/2007	Ade1ph	i, Ma	ryland
Balt	permit. Pages Department of Important: If it any injury or o once.		21. Signature of Funeral Service	Licensee	11	122	2. Name and Addre Dest De	ess of Facility Description	eVol Fune	eral Ho	ome	
	_		8 Herel	JAMI.	of bayland the deal]Ga	iithersbu	rg, MD 2	08/7			Approximate
		8 8	23a Part 1. Enter the disease shock or heart failure. List Immediate Cause (Final	st only one cause o	each line.	. / i	n C-	ng, addir da dardid	o or reapiratory arr	ou,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	1 Y OCCL	rough quence of);	cinta	rchon			-	
	Examiner			H	yperte	USION	l infa					
	P ∺	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a consec	quence of):						
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	YPE_II to (or as a consec		betes					
58760,	death certificate be executed e attending physician and of for use as the burial-transit		,	Due	to (or as a consec	querice orj.						
287	ficate phys s the	edical		d								
Box	leath certifi attending for use as	NA NA	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregn		7=			23d. D	ate of delive	ery
	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 No	4□Pre	re birth 2□Feta egnant at time of d known		∃Ectopic pregnand ∃Other <i>(specify)</i> _			N	lonth	Day Year
J.	The law requires that the de ite has been signed by the a bage 2 should be detached	Physician/M	9 Unknown		_				OO- Did to	<u> </u>		the course of death?
	iires tha signed d be det	þ	Part II. Other significant condi	old cu		suiting in the u	nderlying cause gi	ven in Paπ I.	23e. Dia toi		3 □ Prob	he cause of death?
Records,	w requir been si should	Completed	2 FI GOVIGE	0.00								
Hee Hee	The law cate has b	mpl							24a. Was a autops perfor	sy	prior to co death?	ppsy findings available mpletion of cause of
_	ician: Th certificate rector, pag		25. Was case referred to medic	eal .				26 Place of Do	1□ Yes	2 No	1 🗆 Yes	2□No
5	ysician: s certific director,	o Be	examiner? 1 Yes 2 No	Hospital:	∏Inpatient 2 □] ER/Outpatie	nt 3 DOA Ot	hor:	ath (Check only on		ther (Specia	(v)
0	ding Phys n. After this funeral dir	-	27. Manner of Death		ate of Injury fonth, Day Year)	28b. Time o	f 28c. Inju		28d. Describe ho		` '	<i>,,</i>
Division or	endin ath. or: Af he fur	Certification:	Z L Accident	tigation	, 2-2, 1-2.,	,,		Yes 2 No				
Ĕ	I or Attend after death Director: /	rtific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minor 200. FIG	ace of injury - At h illding, etc. <i>(Sp</i> eci	ome, farm, sti <i>fy)</i>	reet, factory, office		28f. Location (S: City or Town	treet and Nun n, State)	nber or Run	al Route Number,
	pital ours at eral C		29a. Certifier 1 Certify	ring Physician: To	the hest of my kn	owledne, deat	h occurred at the t	time, date and place	e and due to the o	cause(s) and r	manner as s	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical		al Examiner: On th								
	To th vithir comp	Me	29b. Signature and title of certif	ier 🖯		11	/ / >	se number	2	29d. Date sign	ed (Nonth,	Day, Year)
)			Jaco	4) 00	vai	my		16101		4/0	4/2	W/T
			30. Name and thress of person	on who completed c	ause of death (Ite	m 23a) (Type,	Print) SLO	400 P.	VCD SO.	DIALC	MI	20910
	Sta	te	31. Date filed (Month, Day, Yea	IL MU	egistrar's sign	ature	100 710	100,00	UVURIT	121100	1 1	20110
	318	ii.e	U day	6 2007	Maria de la companya della companya	11. 0						

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

Gueden

APR 0

31. Date filed (Month, Day, Year)

D3251

4.30

Keedysuille Maryland 21756

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#18perFH4/13/07, BMW, McCo Certificate of Death Reg. Na.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edward Newman Jr 03 29 2007 2:45am^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thomas Moore Nursing Home Prince George's Hyattsville Birthplace (State or Foreign Country)
 DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ★ M 2 🗆 F Director 40 577-98-0563 Usual Residence of Decedent 02/19/67 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits **Funeral Director** Y☐Yes 2☐No Md Montgomery Montogomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9606 Horizon Run Road 20886 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Be Completed by 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Warehouse Management 18. Mother's Name (First, Middle, Maiden Surname)
SSRETTA Newman 17. Father's Name (First, Middle, Last) unkown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8601 Flower Ave#301 Aunt Takoma Park, Md 20912 Sherrie Newman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/4/07 Beltsville, Md Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Shead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final altoman Immunode freeze Syndroye **Physician** disease or condition resulting in death) RARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the bursh-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) icensburged Hyn Itsville MD 20781

State Registrar 31. Date filed (Month, Day, Year)

APR 0 4 2007

32 degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav April 2007 11:05 P M 3 Maria Tina Natoli 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 1 □ M 2(X) F 78 Yrs July 31,1928 Italy 578-42-2236 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 No Potomac Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 11518 Deborah Drive 20854 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hair Stylist Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antonia Natoli Antonio Cicero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13104 Englewood Drive, Silver Spring, MD 20904 Rosario Natoli / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National April 10 Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Licens - hue TRACY A Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYELDDYSPLASTIC SYNDROME MOC disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPTICEMIA 1 | Yes 2 No 3 | Probably 4 | Unknown PANCY TO PENIA

Physician /Medical Examiner

attending physician and for use as the burial-tran

signed by the a

has

To the Funeral Director: After the completely filled in by the funeral

death.

hours after To the Hospital or within 24 hours a

page this certificate

Records.

or Vital

Division

þ

Completed

Be

2

Certification:

Medical

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

is 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than "

72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

24a. Was an autopsy performed

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referre examiner? 1 ☐ Yes 2 📉	
27. Manner of Death	
1 Natural	5 Pending
2 ☐ Accident	investig

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

DR. #4100 BETITESDA, MO 20817

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE PRIEGO, MD

31. Date filed (Month State Registrar

20

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 MARCH SYLVIA I, RICHMAN 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🕱 F Yrs. 89 MAY 11, 1917 NÉW YORK 051-09-4567 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 DXYes 2 □ No MARYLAND MONTGOMERY ROCKVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 USA 1801 E. JEFFERSON STREET APT.338 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INTERIOR DECORATOR DECORATING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA SCHORR SIDNEY IVES ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Heath Important; If item 27 any Injury or other troonce. HELEN L. RUBIN/DAUGHTER 12417 GOLDFINCH COURT, POTOMAC, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State BETH MOSES CEMETERY 04/01/2007 | PINELAWN, L.I., NY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARY MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CALOTO PULMEN MY Physician /Medical Due to (or as a consequence of): Examiner RUSP FRATURY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner RUPTUNED burial-tran Due to (or as a consequence of) death certificate be the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ HO Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Historyn page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 100 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Thpatient 2 46 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Euneral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

APR

04

DHMH 17 Rev 1/2001

3:05

3/30/07

Vital

Richman,

SUBUR

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician 7:29 A PAULINE REICHENBACH APRIL 2007 Ε. 3, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs Director 204-09-8670 88 FEB. 21, 1919 PA. Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23a or 28a-f show Tra Medical Examinar must be notified at 1X Yes 2 □ No Director MD. PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 38th AVE. Funeral 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 No It Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 OFFICE MANAGER BLUE CROSS BLUE SHIELD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be 2 WILLIAM Ρ. BERTHA STOHLER. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health if 38th AVE., HYATTSVILLE, MD. 20782 DIANNA GUTOSKI/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
sny Injury or ott 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April4,2007 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final PNECENTA. RSPILITEON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner METHENES SCERNITEC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed use as the burial-transit CORONARY and resulting in death) Last Due to (or as a consequence of) Box 68760 nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2₽No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2D No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) 1 Yes 2 No Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mannes of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MB 57614 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) CARROLL AJE. IAKona OLEMAN 160x) 32. Signature 31. Date filed (Month, Day, Year) State APR 04 2007 Registrar

			For State Registrar		State	of Mary	land / De/ <i>C</i>	partme <i>ertifica</i>			and M	ental Hy	giene, Reg. No.	200	7 1	2842
П	4.6		Decedent's Name (First,)	Middle, La	nst)							2. Date of Do	eath Day	Year		ne of Death
	Physicia /Medic		Frances				Russell					April	4,	2007	10:	53 P M
	Examin		4a. Facility Name (If not inst	itution, giv	e street and no	umber)		4b. Cit	y, Town, or					County of De		
			1303 Dil:			T-9 A . //		- If Lind	Silver 1 Year	er Spr	_	8. Date of Bi		Montgom	-	ata as Earaign
	Funeral Director		5. Social Security Number 578-28-3682		Sex 1 □ M 2 🗷 F	7. Age (I	n yrs. last birtho	Month:		Hours	Min.	(Month, D	ay, Yea <i>r)</i> 16, 19		Marylar	ate or Foreign nd
	pur w		Usual Residence of Decede 10a. State 10b. Co			10	Oc. City, Town o	r Location							10d. Insid	le City Limits
	Maryla f sho ied at	ē	Maryland Mon	ntgome	rv			Si 1	ver Sp	rine					1 🗆	Yes 2█No
	r 28a- notif	Director	10e. Street and Number	10Bome	~)				ip Code				10g. Citiz	zen of What 0	Country?	
	h with		1303 Dil:	ston R	load				2	0903				U.	S.A.	
	ems er mu	Funeral	11. Marital Status		12. Was De Armed F	orces?	er in U.S.	13. Was Dec	edent of Hi becify Cuba	spanic Ori n, Mexicar	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0- 1	14. Race - An Black, Wh		n,
36	or it	by Fu	1 Never Married 2		1 ☐ Yes If Yes, G Year or	2 ☑ No Sive		1 ☐ Yes	2X No	Specify:				Specify:	White	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at			edent's E		Dates.	16a. D	ecedent's Us	sual Occup	ation			16b. Kir	nd of Busines		
5	nin 72 n "na Medic	Completed	(Specify only Elementary/Secondary (0	highest gr	ade completed	(1-4or 5+)	(G	ive kind of y fe. DO NOT	vork done d use retired	luring mos)	t of worki	ng				
212	d with giene er tha	ĕ	9					Account	ing Cl					C & P		
Maryland	should be filed and Mental Hygi marked other matic event, t	Be	17. Father's Name (First, M	iddle, Las	t)					18. Mothe		(First, Middle		•		
<u>yla</u>	should be and Mental s marked o	ဥ	Edward Davi									Louise			75.0-4-1	
Jar	12 sh h and 7 Is m traum		19a. Informant's Name/Rel					-				al Route Num Spring,				
	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Janet Carafe 20a. Method of Disposition	111 -	Daugnter		20b. Place of D					Date	_	cation - City		te
more,	Pages nent of int: If it		1 🖫 Burial 2 □ Crema 4 □ Donation 5 □ Ot			n State	Gate of				4/10/	/2007	Silv	er Spri	ng. Mar	vland
altir	permit. Pag Department important: I any injury o once.		21. Signature of Funeral Se				Oate of	22. Name	and Addres	s of Facili	ty			353 \$		
m	Der imp	8 /	Moder			-		11800	New Ha	mpshir	e Ave	ome, Inc	lver Sp	pring, M	laryland	20904
			23a. Part1. Enter the disea shock, or heart failure	se, or cor List only	nplications that	t caused the each line.	e death. Do no	enter the m	ode of dyin	g, such as	cardiac o	or respiratory	arrest,		Approx Interva	dimate Il Between and Death
8	Physician		Immediate Cause (Final disease or condition		а. С	ongest	ive Heart	Failur	e						2 ye	
	/Medical Examiner	ш	resulting in death)				consequence of)									
	- Carrier	<u>.</u>	Sequentially list conditions if any, leading to immediate		D		Stenosis consequence of)	:							Unkn	IOMI
	nted Insit	i i	Cause (Disease or injury	<											1	
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	- 1	C. Due to	o (or as a c	consequence of)	:								
58760,	ysicia	edical		-	d											
_			IF FEMALE:		-										1	
Box	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as it	Physician/M	23b. Was decedent pregna in the past 12 months			e birth 2	Fetal death	3 □Ectopic		1			2	23d. Date of o Month	delivery Day	Year
0	the a	sic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown		4∐Pre 9□Unl		ne of death	5 ☐ Other	(ѕреспу)							
<u>α</u>	that the de ned by the a detached f		Part II. Other significant c	onditions	contributing to	death but	not resulting in t	ne underlyin	g cause giv	en in Part I	ı.	23e. Dio	I tobacco u	ise contribute	to the cause	e of death?
gp	uires signe	d by	Chronic R	enal I	Disease							1 🗆	Yes 2	x No 3 □	Probably	4 □Unknown
Records,	sw requir s been si should i	Completed	Atherosc1	ernti	Heart D)i sease						24a. Wa				lings available
Re	The lay	omp	Renegoser	CIOCI	neure 1	100000							opsy formed? 2 ☑ No	death		of cause of
or Vital	lan: ortifica ctor, p	Be C	25. Was case referred to n examiner?	nedical					т	26. Place	e of Deat	h Check onl				
7	Physician: this certificatal director, I	오	1 ☐ Yes 2 🔀 No		- Laurence		2 ER/Outp			4 🗆 🖂		ome 5 ⊠ Re			pecify)	
	ing P	ü.		Pending	(Mi	te of Injury onth, Day \	Year) 28b. Tir Inj		28c. Injui Wor			28d. Describ	e how injur	y occurred		
Sio	Attending r death. ector: After by the fune	icati	3 Suicide 6 □	nvestigati Could not	be 28e Pla	ce of injury	/ - At home, farn			Yes 2□	INO	28f. Location	(Street an	id Number or	Rural Route	Number,
Division	lor A after a Direc	Certification:	4 Homicide	determine		ilding, etc.		,	,			City or T	òwn, State	9)		
_	To the Hospital or Attending Physician: The within 24 hours after death. (To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 🕱 Co (Check only 2 🗆 Me	ertifylng F edical Ex	aminer: On the	the best of basis of e	my knowledge, examination and	death occur or investiga	red at the ti	me, date a opinion, de	nd place, ath occur	and due to the	ne cause(s) e, date and) and manner d place, and o	as stated.	use(s)
	o the o the o the omple	Med	29b. Signature and title of	certifier	anu m	annor state	~		29c. Licens	e number			29d. Dat	te signed (Mo	onth, Day, Ye	9ar)
			• O	مرزف	2		NO).		D37	7801			Apr	i1 5, 20	007	
	13		30. Name and address of	erson wh	o completed ca	use of dea	th (Item 23a) (T	ype, Print)								
_			Amit Kumar F		shi, M.D.	., 121	Congress	ional L	ane, Su	ite 40	09, Ro	ockville	, Mary	1and 20	852	
B	St Regist	ate rar	31. Date filed (Month, Day,		107	Registrar	's Signature	berte	9							

			1 - For Amend #9 Per			Cei	Tilicate of	Dealli		Reg	g. No.		
	Physici	an	1. Decedent's Name (First, Middle, La	st)						ate of Death	Day	Year	3. Time of Death
	/Medic		Johng Nam	Rhim						April 3,			8:20 a ^M
	Examin	er	4a. Facility Name (If not institution, given	e street and nu	mber)		4b. City, Town, or	r Location of D	eath		4c. County of	f Death	
			Manor Care Nurs		"			thesda	Uro la o	1.51.11		tgome	-
	Funeral Director			Sex 12SM 2□F	7. Age (In yrs. 70	Yrs.	If Under 1 Year Months Days		Min. (A	ate of Birth Month, Day, Y cember 2		9. Birthpl Count Kore	ace (State or Foreign try) a
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ncation					10	Od. Inside City Limits
	sho	ក	,		100.01								1 ☐ Yes 2 ☑ No
	the A	Director	Maryland Montgom 10e. Street and Number	ery		веті	nesda 10f. Zip Code			100	g. Citizen of W	hat Count	
	with	ă						0017		109			y:
	ne 23	era	10250 West Lake 1	1	edent Ever in U	J.S. 13.1	Was Decedent of H	0817 Ispanic Origin	? (Specify Y	es or No-	14. Race	- America	an Indian.
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "netural", or iteme 23a or 28a-f show other then "netural", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	by Funerai	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 🗷 No ve		f Yes, specify Cuba 1 ☐ Yes 2 🔼 No	n, Mexican, Pi Specify:	uerto Rican	i, etc.)	Specify:	, White, e	ian
21215-0036	ture cal E	ed	15. Decedent's E			16a. Dece	dent's Usual Occup	ation	3 - 47 1	16	6b. Kind of Bus		
15	in 72 n nel	piet	(Specify only highest gr	ade completed)	4 4 - 5 ()	(Give	kind of work done of DO NOT use retired	during most of	working				
212	y within jiene. r then "	Completed	Elementary/Secondary (0-12)	College (1-40r5+)		Mechani	c			A	utomo	tive
Þ	e filed al Hygie other vent, II	0	17. Father's Name (First, Middle, Last)				18. Mother's	Name (Firs	t, Middle, Ma	aiden Sumame)	
lar	should be nd Mental I marked o	To B	Hak Won Rhim					1	Mu Duck	cyi Choi	Ĺ		
	es 1 and 2 should b of Health and Ments Item 27 is marked r other traumatics		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Rou	te Number, (City or Town, S	tate, Zip	Code)
	and 2 ealth m 27 I		Sherri Ferdowski - 1	Daughter		8701	Fox Hills	Trail, Po	otomac,	Maryla	and 20854		
S.	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	"Bamayal from		Place of Dispo cemetery, crer	sition (Name of natory or other place	(9)	Date	20	Oc. Location - C	ity or To	wn, State
Ě	Pages ment of h ent; if its ury or of		4 □Donation S □Other (Special			rbeck Me	morial Park	4/	5/2007	(Olney, Ma	rylan	ıd
Baltimore,	permit. Page Department of Importent: If eny Injury of once.		21. Signature of Fun ral Service Lice	nsee		Hi	. Name and Addre ines-Rinald 1800 New Ha	i Funera	1 Home, Avenue.	Inc. Silver	Spring,	Mary	land 20904
			23a. Part1. Enter the disease, or corr shock, or heart failure. List only	plications that one cause on e	caused the deat			-					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	E		mor	21'01						Onset and Death
	/Medical		resulting in death)	Due to	(or as a consec			ı					
	Examiner		Sequentially list conditions	b	ail	live	tot	hri	eve				
	si ad	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):							
	and -tran	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a consec	uanea of):						_	
8760,	ficate be executed physicien and s the burial-transit			545 (0	(0) 43 4 00/1360	(derice or).							
	phys s the	dicai		_ d									
×	death certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d. Date	of delive	rv.
Вох	death certif e attending id for use as	Physician/Me	in the past 12 months?	4☐ Pregr	ointh 2 ☐ Feta nantat time of c		Ectopic pregnancy Other (specify)				Mon		Day Year
0	that the de ed by the detached	hys	9 Unknown	9□ Unkn	own								
٣.	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	1 6	eath but not res	sulting in the u	nderlying cause giv	en in Part I.	2	3e. Did toba	cco use contri	oute to the	e cause of death?
rd	w require been sig should b		Dema	nha	,				_	1 🗌 Yes	2 No :	B □ Proba	ably 4 □Unknown
ဝင္ပ	aw as b 2 s	Completed							2	4a. Was an autopsy	24b. W	ere autop	sy findings available
E.	The ete h page	ĕ							_	performe	ed? de	ath?	2No
ita	iclen: Th certificete ector, pag	Be	25. Was case referred to medical examiner?					26. Place of					
2	9 U T	2	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	it 3□ DOA Oth	er: 4 Nursin	ng Home	5 🗌 Residen	ce 6 □Othe	(Specify)
u u	D 90		27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Work	y at k?	28d. D	Describe how	injury occurre	d	
sio	r Attending er death. rector: Afler by the fune	catl	2 Accident investigatio				M 1 🗆	Yes 2 □ No					
Division of Vital Records,	el or At s after d il Direct ad in by	Certification:	4 Homicide determined	289. Place	of Injury - At hing, etc. (Specil	ome, farm, str fy)	eet, factory, office		28f. Li	ocation (Stre lity or Town,	et and Numbe State)	or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	miner: On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in-	n occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	lace, and di occurred at	ue to the cau the time, date	se(s) and man e and place, ar	ner as stand	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1///	= \ \ \ \ \	NAC	29c. License				d. Date signed	(Month, E	Day, Year)
)	1(2)		1 2365	2440		1000	Do	062	435		4/04	120	007
_			30. Name and address of person who SAYED ELS		se of death (Item			enter	D.		Kuill	e, n	1 D 20850
3.	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2	007 32.	gistrar's Signa		ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A^{M} 6:50 April 2007 06 Betty Harlan Rice /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte's Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2XF Washington, D.C. 88 214-34-6245 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 25a or 28a-f show ant; Ite Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Directo Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21713 United States 212 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Grace Morrison Benjamin A. Harlan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $6042\ Mt.\ Phillip\ Rd.,\ Frederick,\ MD\ 21703$ 19a. Informant's Name/Relationship (Type. Print) Marjorie Scuderi / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 8 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Resthaven Crematory Frederick, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 common common common contract the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. 23a. Part1. Ever the disease shock, heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimers /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a Id be detached f 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2⊠ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has k irector, page 2 s autopsy performed? 1□ Yes 2√√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Fac. Hospital: P 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natura 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: in 24 hours after the Funeral Director: After the Funeral Director: After the Funeral filled in by the fu

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month PR

Neal Patalinghug, M.D. 11110 Medical Campus Rd., Ste. 107 Hagerstown, MD gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 0050882

29d. Date signed (Month, Day, Year)

April 7, 2007

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director MD

Funeral

þ

10a. State

Funeral

Director

Physician /Medical Examiner

physician and the burial-transit

as

Division or Vital Records, P.O. Box 68760

Elementary/Secondary (0-12) College (1-4or 5+)	
Elementary/Secondary (0-12) College (1-4or 5+) 12 Years College (1-4or 5+) Administrative Assistant I. B. 18. Mother's Name (First, Middle, Last) Alice Dullege Alic	м.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname))
Morris Abramson Alice Dulcan	
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St	late, Zip Code)
Joel H. Salus - Son 435 18th Avenue, N. E., St. Petersbur	33704
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci	ity or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem. Gdns Apr. 1, 2007 Falls	Church, Va.
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chape	1. Inc.
Conald C. Allottlemeel 1170 Rockville Pike, Rockville, M	aryland 2085
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition Emphysema	Onset and Death 6 Years
resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause United Sequence of Indiated events that initiated events c.	
Jacquetrially last controlled in the property of the property	
resulting in death) Last Due to (or as a consequence of):	
<u>B</u>	
Section Sect	
23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	
1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 U	n Day Teal
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	uuto to the eques of death?
Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.	B Probably 4 ☐Unknown
24a. Was an autopsy pri	ere autopsy findings available or to completion of cause of
performed? de	ath? ∃Yes 2 X No
25. Was case referred to medical 26. Place of Death (Check only one)	
1 Yes 2 No Nursing Home 5 Residence 6 Other	(Specify)
2 Accident investigation M 1 Yes 2 No	
3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	or Rural Route Number,
[0	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Ves 2 No 28c. Injury at Work? 1 Ves 2 No 28d. Describe how injury occurred 28d. Describe	ner as stated. ad due to the cause(s)
	(Month, Day, Year)
D23630 March 29	9, 2007

DHMH 17 Rev 1/2001

State

Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Frank J. Mayo, M. D. 16220 Frederick Road, # 213, Gaithersburg, Maryland 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 0 4 2007

32 Registrar's Signature

			1 - For State Registrar	State o	of Marylar	nd / Depa <i>Ce</i> a	artment of H rtificate of	lealth a <i>Death</i>	and Me		ene 2 (07	12	846
			1. Decedent's Name (First, Middle	e, Last)					2	. Date of Death Month	Day	Year	3. Time of	f Death
	Physici /Medio		HELEN SMOLONSKY	<i>I</i>					MA	ARCH 27	Day 2007	Tear	8:39	P M
parks ()	Examir	er	4a. Facility Name (If not institution				4b. City, Town, o	r Location of	of Death		4c. County	of Death		
			WASHINGTON ADVI	ENTIST HOS	FITAL 7. Age (In yrs.	land hinth day	TAKO	MA PAI		Data of Birth	MON	TGOME		
	Funeral Director		135-12-0550	1 □ M 2 🗓 F	89	Yrs.	Months Days	Hours		Date of Birth (Month, Pay)	(Par)	9. Birthp Cour	olace (State on NJ	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside C	ity Limits
	Mary -f ehc	ট্	MD MON'	GOMERY			ADELPH	Т						2 X No
	r 28s	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of \	What Cour	ntry?	
	23a c	alD	3210 POWDER MII	LL ROAD #1	150			20783	3			US	A	
	tems tems	Funeral	11. Marital Status	Armed Fo			Was Decedent of H	lispanic Orig an, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		e - Americ		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☑ Yes If Yes, Gi Year or D	2□NoWW] ve vates:	II	1□Yes 2∏ No	Specify:			Specify		ITE	
20	72 ho	Completed	15. Deceden (Specify only higher	t's Education		16a. Dece	dent's Usual Occup	ation	of working	16	b. Kind of B	usiness/In	dustry	
2	han han	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d) _	or working					
	Hygie ther t nt, in		12 17. Father's Name (First, Middle,	(ast)			HOMEMAKE		r's Namo /F	First, Middle, Ma		HOME		
Jan	Aental l	To Be	ALEXANDER INFAL						,	rrekovsk		10)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	i i	19a. Informant's Name/Relations MARC SMOLONSKY-				ng Address <i>(Street</i> ICNEILL R							10
ore,	of Hea		20a. Method of Disposition	4 F.D		Place of Dispo	sition (Name of natory or other place	1	Date	_	c. Location -			
Baltimore,	t. Pagi tment tant: ii		1 Donation 5 Other (S	pecify)	GAI		' REMEMBR		21	'2007 CI	ARKSB	URG,	MARYL	AND
Ba	Depar Impor any in		21. Signature of Funeral Service	Licensee		D	Name and Addre ANZANSKY 170 ROCK	-GOLDE	BERG N	MEMORIAI ROCKVI	CHAPI	ELS,	INC.	20852
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	ach line.	h. Do not ent	er the mode of dyir	ng, such as c	cardiac or re	espiratory arres	t,		Approximat Interval Bet	le ween
James Committee	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. A+	heros	dere	for Con	rongr	y Ar	stery o	روح کرن ک	re_	Onset and I	Death
	Examiner		ooding in doding	Due to	(or as a consec	uence of):		•						
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	juence of):								-
	acuted ind transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
58760,	ficate be executed physicien and is the burial-transit	al Ex	resoning in death) Last	Due to	or as a conseq	uence of):								
687	fficate p phys	edlcal		d									1900	
Box	death certifica attending ph d for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant		come of pregna		T-1				23d. Dat	te of delive	ry	
P.O. B	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ŪNo 9 □ Unknown		oirth 2 □Feta nant at time of d own		Ectopic pregnancy Other (specify)				Mo	nth	Day 1	Year
	res that the de signed by the a i be detached f	by Ph	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.		23e. Did tobar	cco use conti	ribute to th	e cause of d	leath?
Records,	w require been sig should b									1 ☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 to	Jinknown
ပ္တ	e law r has be	Completed								24a. Was an autopsy	F	prior to cor	osy findings	available ause of
										performe		death? I□Yes	2□ No	
Ĭ	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 4 🗔		,	Oth			heck only one				
ō	Phys	2	Yes 2 No 2. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	t 3□ DOA Out	4 🗆 Nur:		5 Residence I. Describe how			')	
<u></u>	nding Ph ath. r: After th e funeral	atlor	1 Natural 5 ☐ Pending	g (Mont	th, Day Year)	Injury	Wor	k?¨ Yes 2 ∐ N			,,	00		
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place	of Injury - At he	ome, farm, stre	eet, factory, office		28f.	Location (Stree City or Town, S	et and Numb State)	er or Rura	l Route Num	ber,
	Hospit. 24 hours Funera stely fille	Medical C	29a. Certifier Check only one) Certifyin	g Physician: To the Examiner: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	d place, and h occurred a	due to the caus at the time, date	se(s) and ma	inner as st and due to	ated. the cause(s)
	Fo the	Me	29b. Signature and title of certifier		x/ th	M.D	29c. Licens			29d	. Dațe signed	i (Month, I	Day, Year)	
1	3		James Karm	edy tryl	feel)	~ / ~ T	52	326		1	3/27/	200	7	
~			30. Name and address of person of DR. JAMES KENNE	who completed caus DY LIGHTF	e of death (Item OOT, 76	1 23a) (Type, 1	Print) ROLL AVE	, TAKO	MA PA	RK, MAR	YLAND	209	12	
- 3	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signa	iture	ast 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Cleo Jeanne Smitson April 3 2007 1430 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🖫 F 83 214-18-8658 Director Jan 16 1924 West Virginia Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 1 ☐ Yes 2 ☐ No Director Solomons Maryland Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Dowell Road 20688 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give ★ Year or Dates: ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white ģ 3 ₩idowed 4 Divorced 'natural' Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lab Tech Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert H Harford Christine Anderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Record (PR) 13439 Allnutt Lane Hughland MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) April 7 2007 Olivet U.M. Ce, etery 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Lusby Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. POrt Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILURE /Medical Due to (or as a consequence of): **Examiner** MALMUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed LOSS OF POPETIT as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ NTEROCOCCUS UROSEPSIS 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No VGGINAL CANDIDIASI 24a. Was an MICONON perform 1 Yes 2 3) DEHYDRANON 2 No MIW AZOK MIA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Registra Signature

NID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASEEMA DAWI

31. Date filed (Month, Day,

00064961

HOSPITAL, SUITE

4/03/07

310, PRINCE FREDERICK

MD 20678

110 HOSPIAC

I CANERT MEMORIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2:25 ^{a M} March 31, 2007 James Mullen Stone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Year) Months Days Hours NXM 2□F 79 April 18, 1927 New York Director 080-22-9045 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 IISA 3100 N. Leisure World Blvd., #804 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. M3Yes 2 No If Yes, Give Year or Dates: 1945-76 filed within 72 hours after 1 ☐ Never Married 2 T Married Specify: White 1 ☐ Yes 2 ☐xNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Officer US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and 2 should be file. Health and Mental Health and Mental Health 27 is marked oth other traumatic even? Be Francis William Stone Wilhemina Joanna Titus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 3100 N. Leisure World Blvd., #804, Silver Spring, Audrey M. Stone/Wife Health tem 27 i item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth June 13. 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Arlington, Virginia 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Esopha jeal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed and trar resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day jo 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Renal Cell Cancer, Failure To Thrive. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No aw 24a. Was an Metastatic Lung Disease has certificate 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo P within 24 hours after again.

To the Funeral Pirector: After this of manufately filled in by the funeral differential of the funeral differential of the funeral differential this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending (Month, Day Year) Injury 1 XNatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 4, 2007 d53367

State

1+1

Baltimore, Maryland 21215-0036

Box 68760.

o

٦

or Vital Records,

Division

3411 Olandwood Court, #105, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. gistrar's Signature

Rajan Shyamsundar, M.D.

APR 06

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #1 Per Phy G866 4/24/07 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 200°7 10:15 A M Maxwell Milo Scovel Max Milo Scovel April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 7068 Basswood Road Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 11XM 2□ F Yrs. 92 Director 380-10-6589 July 1, 1914 South Dakota Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 7068 Basswood Rd. 21703 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ∏ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool & Dye Maker Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Pages 1 and 2 should be Thomas Leonard Scovel Adda Mahala Wall ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trauonce. 7068 Basswood Rd., Frederick, MD 21703 Muriel Scovel / Wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 6, Resthaven Crematory 4 □ Donation 5 □ Other (Specify) 2007 Frederick, Maryland 21. Signature of Fundral Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1 Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) pirati **Physician** 1) Neummic mml /Medical Due to (or as a consequence of): Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe репоrmed? 1□ Yes 2☑\No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, P.O. Box 68760, Division or Vital Hospital or Attending after death Director:

filled in by 24 hours a To the Hosp within 24 ho To the Functional

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

GITTR

and manner stated.

29c. License number

D09689

1/ pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 West 9th Street, Frederick, MD 21701 M.D. <u>Austin Pearre,</u>

32. Redistrar's Signature 9

			For State	State o	f Maryland		artment of rtificate o			ental Hy	giene	2007	12050
養	49.	wit.	Registrar 1. Decedent's Name (First, Midd)	lla / act)		Ce.	rinicate o	Deair	1	2. Date of De	Reg. No.		3. Time of Death
	Physici		Norma Jean S							Month	Day	Year	M
1	/Medi Examir		4a. Facility Name (If not institution		mber)		4b. City, Town	n, or Location	of Death	April	6 4c. C	2007 ounty of Death	10:17 AM
	LXuIIII		1281 West 01d	Philadelph	ia Road		North	East				Cecil	
8	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under 1 Ye Months Day	ar If Unde		8. Date of Bir (Month, Da	th		lace (State or Foreign try)
Sin.	Director		215-42-9692	1 ☐ M 2 🗓 F	65	Yrs.	Mondo Bay	yo moulo		July 1			Virginia
	and		Usual Residence of Decedent 10a. State 10b. County	<i>y</i>	10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Maryl f sho ied a	ò	Manual and Con		27	1 17							1 ☐ Yes 2 No
	r 28a-	Funeral Director	Maryland Cec 10e. Street and Number	11	Nort	h Eas	10f. Zip Code	e			10g. Citize	n of What Coun	try?
	h with	O E	1281 West 01d	Philadelph	ia Road		219	0.1			Unite	d State	c
	deat	ner	11. Marital Status		edent Ever in U.S.	13.	Was Decedent of If Yes, specify C		rigin? (Spe			. Race - Americ	an Indian,
9	after or ite		1 □ Never Married 2 □ Mar	rried 1 ∐ Yes	2 X No		ın res, specily o 1 □ Yes 21√2 N			nicari, etc.)		Black, White,	
21215-0036	hours ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or D	ates:		21					pecify: Whi	
15	"nat	Completed		nt's Education est grade completed)		16a. Dece (Give	dent's Usual Oct <i>kind of work do</i> DO NOT use ret	cupation ne during mo tired)	st of workir	ng	16b. Kind	of Business/Ind	lustry
112	withi iene. than	E D	Elementary/Secondary (0-12)	College (I-4or 5+)		Houseke				Pd	cation	
	filed I Hyg other	Be C	17. Father's Name (First, Middle	, Last)			HOUSERE		ner's Name	(First, Middle			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland to chealth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	Elvie Moore					Ze	211a M	Marie D	anie1	.S	
ary	sho and s		19a. Informant's Name/Relations	1 () /								own, State, Zip	Code)
	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		Ardie L. Smitl	h, Jr. / S			vermist		e, Elk	ton, M	aryla	nd 219	21
Baltimore,	Jes 1 of H		20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 □ Bemoval from	State 20b. Plac	ce of Dispo netery, crei	sition (Name of natory or other p	olace)	April	ate	20c. Loca	tion - City or To	wn, State
ţi	tment tant:		4 Donation 5 Other (Specify)	Nort	h Eas	t Metho	dist	10, 2	007	North	East,	Maryland
Bal	permit Depar Impor any In		21. Signatur of Fund at Service	1156			. Name and Add						
	402100		23a. Part1. Enter the disease, o	y compliantions that a	auged the death							st, Mar	yland21901
			shock, or heart failure. Lis	t only one cause on e	ach line.	Do not en	er the mode of t	aying, such a	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a conseque	Diese	AR	REST					(M/s)
	Examiner			Due to	or as a conseque	nce of):			127. 14		27 12		
12		ē	Sequentially list conditions, it any, leading to immediate	b. Due to	or as a conseque	Tice of).	5-101	Nog Con	OUN	1100	45745	375	6 MONTHS
	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S .									
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to	or as a conseque	nce of):							
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d									
9	entifica ling pl e as t	Med	IF FEMALE:										
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come pf pregnand pirth 2 ☐ Fetal d	eath 3	Ectopic pregna				230	 Date of delive Month 	ry Day Year
o.	at the de by the a rtached i	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregr 9⊟Unkn	ant at time of dea own	th 5L	Other (specify))					, , , ,
Δ.	res that t igned by be detac		Part II. Other significant conditi	ions contributing to de	eath but not resulti	ng in the u	nderlying cause	given in Part	l.	23e. Did t	obacco use	contribute to th	e cause of death?
or Vital Records,	uires sign d be	d by		Hamit	ANXIZ	1-1	: MAR	381		10	Yes 2	No 3 ☐ Prob	ably 4 Onknown
00	w require been signature should b	lete	0846	~	.,,,,,,,,	7	1 101	11716		24a. Was	an	24h Wara autor	osy findings available
Re	The lav	Completed		179						auto	osy ormed?	prior to cor death?	npletion of cause of
ta			25. Was case referred to medica	al I				26 Plan	e of Death	1 Yes	2/ X No	1 ☐ Yes	No
>	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 I	npatient 2 ☐ EF	R/Outpatier	t 3 DOA					□Other (Specify	<u> </u>
0	ding Ph n. After th funeral	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date	of Injury 2: th, Day Year)	8b. Time of	28c. Ir	njury at Vork?	2	8d. Describe	how i njury o	occurred	/
<u>i</u>	or:	atic	2 ☐ Accident investi	igation		,,		☐ Yes 2☐]No				
Division	I or Attend after death Director: / I in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 26e. Place	of injury - At homo ng, etc. (Specify)	e, farm, str	eet, factory, offic	ce	2	8f. Location (S City or Tox	Street and I vn, State)	Number or Rura	l Route Number,
	urs urs eral												
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical	29a. Certifier 1 4 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the b									
	o the	Mec	29b. Signature and title of certifie	er 100	y stated.		29c. Lice	ense number			29d, Date s	signed (Month, I	Dav. Year)
	F S F Ö			G8/	M.D.		2	- 23	334		913	APRIL	2007
	p (1.12)		30. Name and address of person	who completed caus	e of death (Item 2:	3a) (Type.	Print)		1		(~	-((1) -	
0	5 44		71177-1. 7	SHAH 2	e of death (Item 2:	154	Hwy. K	VORTH L	E457	~ MD	219	301	
	Sta		31. Date filed (Month, Day, Year)) 32. R	egistrar's Signatur	e d	alle 1					,	
	Registr	ar	APR 9	2007	an s.	1400	nec .						

Division or Vital Records, P.O. Box 68760. attending physician as signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, filled in by

Completed

Be

ဥ

Certification:

INFECTION IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

within 24 hours a

To the Funeral D

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Tyes

27. Manner of Death

1. Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

aac

1 Inpatient

and manner stated.

Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAMES W THE LAK HETAZ HOSTICE DEERSHEN 2004

32. Registrar's Signature

5 ☐ Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

1000 M ,2007 County of Death 1comeco Birthplace (State or Foreign Country) Sharptown, Md. 10d Inside City Limits 1 ☐ Yes 2 X No 10g, Citizen of What Country? Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry

Year

3. Time of Death

Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33925 Race Bridge Road Parsonsburg, Md. 21849 20c. Location - City or Town, State April7,2007 Sharptown, Maryland

700 West Street Hannigan, Short, Disharoon F.H. Laurel, De. 19956

4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2□No

Location (Street and Number or Rural Route Number, City or Town, State)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ? 17 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2007 VIRGINIA Α. TTMKO 11:22p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Center Chestertown Kent tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 29 9. Birthplace (State or Foreign Country)
1919 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🖫 F 87 220-01-0647 Director Usual Residence of Decedent e filed within 72 hours after deeth with the Maryland at Hygiene. other than "natural", or Iteme 23a or 28a-f show 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County r than "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Directo MD Kennedyville Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11784 Augustine Herman Hwy. 21645 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Ď 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cottege (1-4or 5+) Elementary/Secondary (0-12) Office Manager Life Insurance 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Heelth and Mental H lant: If Itsm 27 Is marked ott jury or other traumatic sven Oliver W. Atwell Nellie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Miller (nephew) 30241 River Rd. Millington, MD. 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removat from State permit. Page Depertment o Important: If any Injury or once. Kennedyville Cem. 4/20/07 Kennedyville, MD. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. 21. Signature of Funeral Service License Schaech 21635 M00510 118 West Cross St. Galena, MD. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** days /Medical Examiner COS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effer death. physicien end s the burial-transit 4 Jor. 1910 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai attending pl IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed to should be deta Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes t autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Naturat 5 Pending investigation 1 Yes 2 No 2 Accident efter deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral D 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D 5 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 6602 Church Hill Rd. Chestertown, MD. 21620 Frederick Delboy, M.D. 31. Date filed (Month, Day, Year) APR 2 0 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7-02880		Please Type or Print i					ible.	1 2 2 27
oshua Dean T	hras	ner State of Maryla 1- For State	and / Department		nd Mental Hy	giene	200	7 1285
Discola		Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of	or Death		Reg. 2. Date of Death	No.	3 Time of Death
Physic Medical Exam		Joshua DeAn	Thrasher	P			Day Year 07	0843 hrs
Mark.		4a. Facility Name (if not institution, give street and no			or Location of Death	1 10111 101	4c. County of Deat	h
		14709 Wood Street		Cumberlar	nd		Allegany	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Ye Months Da		1	(MM/DD/YYYY) 9 Bi Forei	an a
Director		212-27-2595 1XM 2 F	27 v	rs.		February	16,1980 0	ountry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
Š	<u>_</u>	Macyland Allegany	Cumberla	nel				1 Yes 2 No
Maryland 28a-f show d at once.	Director	Maryland Allegany 10e. Street and Number	0 0 00 1111	10f. Zip Code		109	Citizen of What Cou	intry?
ith the Maryland 23a or 28a-f sho notified at once	ä	12812 Bunting Stree		2150			4.5 A.	
tth wit tems 2 st be n	Funeral	11. Marital Status 1 X Never Married 2 Married Armed F			lispanic Origin? (Spe an, Mexican, Puerto F		14. Race - Ame White, etc.	rican Indian, Black,
ter dez ", or i		3 Widowed 4 Divorced If Yes, Give Ye.	2 X No	Yes 2 N	o specify:		Specify: W/	vite
ours af atural	d by	15. Decedent's Education (Specify only highest gra	de completed) 16a. Deced	ent's Usual Occup	ation (Give kind of w		6b. Kind of Business	
136 hin 72 ho e. than "na edical Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	•	e. DO NOT use retire	ea)	C	
21215-0036 suld be filed within 72 marked other than ' in event, the Medical	Completed	17. Father's Name (First, Middle, Last)		urveyo	7 R 18 Mother's Name	(First Middle Ma	Survey	109
21215-003 uld be filed with Mental Hygiene marked other ti	Be C	John Nelson Thrasher	, III		JAnet			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumaite event, the Medical Examiner must be notified at once	일	19a. Informant's Name/Relationship (Type, Print)	19b. Mail		et and Number or Ri	ural Route Numbe	er, City or Town, Stat	
and 2 shou lealth and?		Janet Thrasher - moth						21502
ore, No. 18 I and St. Health If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal fi	20b. Place of Disp crematory or	other place)			20c. Location - City o	1
imo Page ment c		4 Donation 5 Other Specify:	Cumberla	nd Cremi	Hory April	119,2007	Comberlan	I, Marylanes
Baltimore, permit Pages I as Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22	Name and Addre	ss of Facility Eich	iern - Mch	Cenzie Fune	1 1 120
Physician	<u> </u>	Part I. Enter the disease, or complications that of	aused the death. Do not ente	the mode of dying	a, such as cardiac or	respiratory arrest	t, shock, or heart	Approximate Interval
Medical		failure. List only one cause on each line.	and methadone in			, ,		Between Onset and Death
Examiner	i	del no de la companya del companya del companya de la companya de	a consequence of):	CONTRACTOR	-		······	
	Ļ	Sequentially list conditions, b.						
	Examiner	cause. Enter Underlying Cause	a consequence of):					
In a city	Xan	(Disease or injury that initiated events resulting in death) Last	a consequence of):					
executed an and all - transi	<u>a</u>	X UNPENDED AMENDED						
760, ficate be exe g physician the burial -	ledi	11 22 22 9 22	7,28a-f, perME, g	3866, 4/21/	07 TT		23d. Date of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death to the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the fineral director, page 2 should be detached for use as the burnt	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	birth 2 🔲 I	Fetal death 3	Ectopic pregnar	псу		Day Year
ox 687 eath certific attending	sici	1 Yes 2 No 9 Unknown 9 Unknown		Other (Specify)				
O. B. tr the de by the ached f	R	Part II. Other significant conditions contributing t		e underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords, P.O. w requires that th is been signed by should be detach	d b					1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
rds, requir	Completed					24a. Was an autopsy		utopsy findings available completion of cause of
tal Reco	E G					perform	ed? death?	
III: The ror, pa		25. Was case referred to medical		26.Pla	ce of Death (Check o			
Division of Vital Records, tal or Attending Physician: The law require stafter cleath by Director. After this certificate has been sided in by the threat director, page 2 should be lost in by the threat director, page 2 should b	o Be	examiner? 1 • Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatie	ent 3 DOA			esidence 6 🗸 Othe	er: Scene
n of Vi ling Physi After this funeral dir	n: T		e of Injury 28b. Time on the Day, Year)			28d. Describe ho	w injury occurred	
Sior Attend death crtor:	Certification:	2 Accident Investigation Fnd	4/15/2007 Fnd 8:	40 an	Yes 2 X No	unknown	root and Number or P	ural Route Number, City
Divisi pital or Att ours after de reral Direct filled in by	ij	Suicide S X Could not be determined (Specify	ce of Injury - At home, farm. st Found in car	reet, ractory, office	building, etc.	or Town, Sta 14709 Woo		rland, MD
lospita 4 houn		4 Homicide 29a Certifier 4 Continue Physician To the be		curred at the time.	date and place, and			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis and manner:	of examination and/or investig	gation, in my opinio	on, death occurred at	the time, date an	nd place, and due to t	he cause(s)
<u> </u>	Me	29b Signature and title of certifier			nse number		29d. Date signed (M	onth, Day, Year)
		Carol Ha	llai-	0.0	.M.E.		April 16, 2007	
4		30. Name and address of person who completed cau		Street Baltin	nore MD 24204			
V		Carol Allan, MD Assistant Medical 31. Date filed (Month, Day, Year)	egistrar's Signature	oueer, bailif	nore, MD 21201			
S Regis		APR 2. 0 2007	I Agan					

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 6:50 a_M April 2, 2007 Dang Trinh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 □ F April 15, 1943 Vietnam Director 215-04-9747 63 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐Yes 2X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4408 Medallion Drive death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Asian Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Assistant Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Li Ngoc Lan ပ Tuyen Trinh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 4408 Medallion Drive, Silver Spring, Maryland 20904 Sang Trinh - Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Parklawn Memorial Park & 1 x Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/2007 Rockville, Maryland Menorah Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Immediate Cluse (Final **Physician** Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i o 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death.
I Director: After to in by the funers After Division Injury 5 Pending investigation 1 X Natural 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and fittle rtifie 29c. License number 29d. Date signed (Month, Day, Year) April 2, 2007 MD50791 ho completed cause of leath (Item 23a) (Type, Print) 30. Name and address of person y 2101 Medical Park Drive, Suite 305, Silver Spring, Maryland 20902 Damirez T. Fossett, M.D. 31. Date filed (Month, Day, Yea egistrar's Signature State 04 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Pauline Whittington Tait 3:32p April 3,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🗔 F Hours 577-56-8658 88 Director June 23,1918 England Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Montgomery Chevy Chase 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Connecticut Ave, #712 20815 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HEW Elementary/Secondary (0-12) College (1-4or 5+) US Government Director of Public Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Whittington Marjarie Hood 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Masi/ Daughter 7961 Pond Haven Lane, St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4-6-07 National Crematory 4 Donation 5 Dother (Specify) Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Massive Intracranial Hemorrhage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, he and L. immudel, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed iding physician and se as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hypertension No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No £ 2 X ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1X Natural 5 Pending death. investigation 2 Accident 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0044394 April 4,2007 MI

State Registrar 31. Date filed (Month, Day, Year) APR 0 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		_ For	Type or Print in Black In State of Maryland / Depart	artment of Health and	-		1 12856		
		1 - State Registrar	Ce	rtificate of Death	Re	g. No.			
Physic /Med		Decedent's Name (First, Middle, La MARION E	THOMPSON		2. Date of Death Month APRIL	Day 2007	3. Time of Death 10:45 AM		
Exam		4a. Facility Name (If not institution, given FREDERICK MEMORE)		4b. City, Town, or Location of Dea FREDERICK	ath	4c. County of Death FREDERICK			
Funera Directo		5. Social Security Number 6. \$ 435–46–5795	Sex 1X M 2□ F 7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Mir		(Ye <i>ar</i>) 9. Bir (Ci	Birthplace (State or Foreign Country)		
3	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits		
28a-f s	Director	MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Co							
la or	<u> </u>	207 Montgomery	USA	ountry.					
a rand 2 should be there within 7 chouls after beart with the waryand tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 D No	21771 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
"natur edical	Completed	15. Decedent's E (Specify only highest gr	ade completed) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 1	6b. Kind of Business	/Industry		
jiene. r than the M	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Mason		Public School			
ed other	Be	17. Father's Name (First, Middle, Last Noel Thompson	")		Name (First, Middle, Maiden Surname) Purvis				
= 2 元	To	19a. Informant's Name/Relationship (Elaine Thompson		ng Address (Street and Number or F Montgomery Ave.	Rural Route Number,	City or Town, State, MD 2177			
		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery 04/10/2007 Mt. Airy, MD							
permit. Fage Department C Department of Important: If any Injury or any	1	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)		2. Name and Address of Facility St 8 East Ridgeville ter the mode of dying, such as cardi	Boulevar	d Mt. Air			
e attending physician and deforuse as the burial-transit	Examiner								
the attending physician ned for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of de Month	slivery Day Year					
as been signed by the a 2 should be detached to	þ	Part II. Other significant conditions		o the cause of death?					
ate ha	Completed				24a. Was an autopsy perform	sy prior to completion of cause of death?			
certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only one) 11 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
inel inel	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		suny)		
or Attending after death. Director: After In by the funer	Certification:	3 Suicide 6 Could not b	e 280 Place of injury. At home farm st		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,		
o the hospital of Attental thin 24 hours after death. o the Funeral Director: A completely filled in by the fu	Medical Co								
ithii out	ĭ	29b. Signature and title of pertifier		29c. License number	29	d. Date signed (Mon	th, Day, Year)		

State

29b. Signature and title dertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald E. Miller, MD 4 Culwell Drive M Mt. Airy, MD 21771

31. Date filed (Month, App Near)

Registrar

D26499

29d. Date signed (Month, Day, Year)

4-9-07

DHMH 17 Rev 1/2001

13

State Registrar Jesse

31. Date filed (Month

North Wolfs Street, Baltimore, Maryland 21287

Kim, The Johns Hopkins Hospital

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2007 HAZEL GERTRUDE WALKER 0645 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FROSTBURG VILLAGE NURSING CENTER FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 96 Yrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F 10-3-1910 170-18-3034 PENNSYLVANIA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or itame 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at ₩ Yes 2 No MD ALLEGANY FROSTBURG Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code UNITED STATES 21532 100 HONEYSUCKLE LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, et permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or its any Injury or other traumatic event, tra Medical Examina 1 ☐ Yes 2 X No If Yes, Give Year or Dates: WHITE 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TRENE BELL ROMESBURG WILLIAM ROMESBURG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY WALKER DAUGHRER 2617 BROAD STREET, PARKERSBURG, WV 26101 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition UNION CEMETERY 1 Burial 2 □ Cremation 3 □ Removal from State MEYERSDALE, PA 4-15-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 Twess M00547 Panti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 8NG 58TIV /Medical Due to (or as a consequence of): Examiner ORO-NARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? 1 Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA this filled in by the funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 5 Pending 1 TYes 2 \ \ \ No 2 Accident investigation Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct 4 Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier D25638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dway Frostburg Maryland 215-32 ATURNINA Registrar's Signature 31. Date filed (Month, Day, Year) State APR 20

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar		State of Ma	-	•	ate of L		Mental H	ygierię Reg. No		1	12000
			1. Decedent's Name	(First, Middle, Las	it)					2. Date of D	eath Day	/ Ye	25	3. Time of Death
	Physici /Medic		Rickey Hu	intan Wil	lis, Sr.					March		007		0.38 p M
	Examin		4a. Facility Name (If ri	not institution, give	street and number)		4b. (City, Town, or	Location of Dear	th	4c.	County of I	Death	
		Director	Holy Cross						Spring			ontgome	ry	
	Funeral		5. Social Security Nur	18	9X 7. Age ☑M 2☐F	(In yrs. last bir	Yrs. If U	nder 1 Year ths Days	If Under 24 Hrs Hours Min		irth Day, Ye <i>ar)</i>	9.	Birthpla Counti	ace (State or Foreign
	Director		Usual Residence of D)		64	113.			Oct. 19	194	2 Wa	shin	gtan, DC
	land w			10b. County		10c. City, Tow	n or Location						10	d. Inside City Limits
	Mary Heth		Maryland	Montac	YMONT Z		C4 1							1 ☐ Yes 2 ☑ No
	r 28e		10e. Street and Numb		mery			Spring I. Zip Code			10g. Cit	izen of Wha	t Count	ry?
	30 o		10213 Gra	nt Avenue				20910				***	17	
	deat	Funerai	11. Marital Status	110 110 01100	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was D		spanic Origin? (S n, Mexican, Puer	Specify Yes or N	10-	14. Race - A Black, V		
တ္	or its	E/	1 Never Married		1 ☐ Yes 2 📆 N If Yes, Give	lo		s 212 No	Specify:	to Filoati, Bto.)				ic.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "neturel", or iteme 23e or 28e-f ehow event, the Medical Enerthraf must be nuffied at	d by	3 Widowed 4	Divorced	Year or Dates:							Specify: Whit		,
<u>.</u>	net dice	To Be Completed	(Specify	 Decedent's Ed only highest gra 	lucation de completed)	16a.	(Give kind o	Usual Occupa of work done of OT use retired	luring most of wo	rking	16b. K	ind of Busin	ess/Indi	ustry
2	withir the same of		Elementary/Second	dary (0-12)	College (1-4or 5	+)	me. DO N	or ase reared	,		_			
7	filed wi Hygien other th		17. Father's Name (F	irst. Middle, Last)		Lin	ousine	Driver	18. Mother's Na	me (First, Midd		rvice Sumame)		
au										, , , , , , , , , , , , , , , , , , , ,				
2	# 5 E E		Brooke All:	-	Type, Print)	19b	. Mailing Add	ress (Street a	Clorence E	Wans urai Route Num	ber, City o	r Town, Sta	te, Zip (Code)
S	12 12 12 13 13		Rickey H. W	illia Jr	/ Son	100	12 / 3000		04.7	wasan kanana in k	D 0000			
ē,	- 1 6 5		20a. Method of Dispo	sition		20b. Place of cernetes	Disposition	(Name of	, Silver	Date	20c. Lo	cation - City	y or Tow	vn, State
Ë	Pages nent of int: if its			Cremation 3 ☐ Other (Specify	Removal from State /)	1		Cemeter	*	•	Silver	Sorin	or. Ma	aryland
Baltimore,	permit. Pages Department of Important: If It eny injury or c		21. Signature Fund	eral Service Licen	598		Franc	e and Addres	s of Facility				31.	2010
m —	82 5 8		21. Signature Fineral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring MD 20901											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate finterval Between											
	Physician		Immediate Cause (Final disease or condition Aspiration Pneumonitis											
	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
	LAdillilles		Sequentially fist conditions, b. Small Bowel Obstruction											
	ed sit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
	xecut and II-trar	xan										-		
68760	ificate be executed prhysicien and as the burial-transit	by Physician/Medicai												
89					. 0.									
Box	eati certifi attending I fo: use as		in the past 12 months? 1								23d. Date of defivery			
o. D	The law requires that the death certive has been signed by the attending age? should be detached for use a										Month Day Year			
P.O.	at the de by the a													
	res that igned b										co use contribute to the cause of death?			
ord	w require been si should I		Renal I	Renal Insufficiency, Leukocytosis, Pulmonary Embolus 1□Yes							Yes 2	2 No 3 Probably 4 Munknown		
ပ္	law law las b	Pie			24a. Was an autopsy						opsy	24b. Were autopsy findings available prior to completion of cause of		
E		Be Completed									formed? 2⊠ No	deal	th? Yes 2	2□ No
<u> </u>	nysicien: Th nis certificate director, pag		25. Was case referred to medical examiner? 26. Place of Deat							ath (Check only	th (Check only one)			
0	Phys this ral dir	<u>1</u>	1 Impatient 2DXEH/Outpatient 3L DOA 4 Nursing Home 5 Residence 6 Other (Specify))			
Division of Vital Records,	Attending Physician: or death. octor: After this certific by the funeral director,	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Loc											
ls!	or Attendia after death. Director: A in by the fu	fica								Location (Street and Number or Rural Route Number,				
á	s after	Sert	4 Homicide building, etc. (Specify)							own, State	State)			
	To the Hospitel or At within 24 hours after d to the Funeral Direct completely filled in by	Medical C	2/3 Certifying Physician: To the best of my knowledge death occurred at the time, date and due to the nause(s) and manner as stated. (Check only one) Additional Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To th Within To th:		29b. Signature and til	tle of certifier				29c. License	number			te signed (N		Day, Year)
)	15		1 0	527	1	-		D624	17 5		3/:	31/07	7	
-	(3			ss of person who	completed cause of de	eath (ftem 23a)	(Type, Print)	len R	d- siti	ver Sn	rine	MD	20	917
	Sta Registr		31. Date filed (Month)	, Day, Year)	32 degistra	ar's Signature	house	E)	.d. siti	T T	'')			

		•	For State Registrar	State of Mary		rtment of H			ene g. No. 200	7 1286	
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	2007	3. Time of Death	
	/Medic	al	TISA ANNETTE WATERS					MARCH 2	4c. County of Deat	2:01 PM	
1	LAGIIIII	44	Shady Grove Adv				Rockvil		MONTGO		
	Funeral Director		5. Social Security Number 220−04−5780 6. Sex 1□		yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan . 2,	^Y 1969 Ma	hplace (State or Foreign untry) ryland	
	rland ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
036	e Man 3a-f sh tiffied	Director	MD Montgo	nery		Germant	own			YQYes 2 No	
	h with th 23a or 24 st be no		10e. Street and Number 18047 Cotta	ge Garder	p#101	10f. Zip Code	874	10	g. Citizen of What Co Ü . S . A .	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status **MXNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: E		
21215-0036	hin 72 ho e. an "natu! Medical	To Be Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	16a. Deced (Give life. I		during most of workird)	ng 1	16b. Kind of Business/Industry			
	led wit tygiene her tha nt, the		12th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		Deli Wo	18. Mother's Name	(First Middle N	Giant F	ooa	
lanc	ld be fi ental h ked ot ic ever		Robert H. Wate:	rs, Sr				E. Han			
Maryland	nd 2 shou Ith and M 27 Is mar r traumat		19a. Informant's Name/Relationship (Typ Robert H. Water	· .	19b. Mailir				City or Town, State, 2		
Baltimore,	Pages 1 ar nent of Hea int: If Item ? iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dopation 5 ☐ Other (Specify)	2	Place of Dispo cemetery, cree Sate of	Heaven	Cem 4/	5/07 5	20c. Location - City or Silver Sp	ring, MD	
Balti	permit. Departr Importa any Injt	İ	21. Sign ture if Funeral Service Legisla	Snaus	Bu 6 24	2. Name and Addre	ss of Facility SNO ashington	n St,Ro	ckville,	OME, P.A. MD 20850	
. 10	Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath disease or condition Approximate Interval Between Onset and Doath Onse								
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a co		eneur	mus			MOVINS	
	ā k w	ner	Sequentially list conditions, liany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sue to (or as a co	nsequence of						
	ificate be executed graphysician and is the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
68760,	ate be e hysiciar the buri	edical E	d.								
O. Box 68	ath certi attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	ivery Day Year	
σ.	w requires that the de been signed by the s should be detached	To Be Completed by	Part II. Other significant conditions com	tributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
or Vital Records,								24a. Was ar autops perform 1□ Yes	y prior to	utopsy findings available completion of cause of 2 □ No	
Vita	Physiclan: Th r this certificate ral director, pag		25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death		,		
Division or \	dis y		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred						cify)	
	or Attending fter death. Ilrector: Afler in by the fure	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (5	At home, farm, sti Specify)	M 1 ☐ Yes 2 ☐ No Street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)				ural Route Number,	
	Hospital 4 hours Funeral tely filled			ician: To the best of mer: On the basis of example and manner stated	amination and/or in						
	To the within 2 To the comple	Medical				29c. Licens	se number 29462	29	9d. Date signed (Mon.	th, Day, Year)	
	V		30. Name and address of person who could be seen to see the seen to see the seen to see the see that the see	mpleted cause of death	(Item 23a) (Type,	Print)	1 / D	PorVII	(It m)	2000	
	Sta	ate.	31. Date filed (Month, Day, Year)	32 / egistrar's	225 HA Signature	DYG KO	VE NU)	NOCKVI	140,1110	7000	
	Sta Regist	rar	APR 0 4 200	7 Brogue	K de	acte)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Physician April 7, Richard Thomas Whisman 9:02 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Co. 3210 Old Largo Road Upper Marlboro 8. Date of Birth (Month, Day, Yea Oct. 3, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1₩ 2□F Months 215-38-4129 65 1941 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Director MD P.G. County Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 Old Largo Road 20772 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. XYes 2 Yes, Give 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 X No White Specify 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Home Improvement Contractor Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmett Whisman Mae Patton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Whitman (Wife) 3210 Old Largo Road, Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aprilate 12. 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cem. 2007 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fund 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer - non small cell disease or condition resulting in death) months Due to (fr as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by chronic obstructive lung disente 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ပု 4 ☐ Nursing Home 5 😾 Residence 6 ☐ Other (Specify) 27. Manne eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, physician s the buria Division or Vital Records, P.O. Director:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he matter and once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier tanua Muller S

29c. License number D0026607

29d. Date signed (Month, Day, Year) April 9, 2007.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward T. Cullen, M.D. 6188 Oxor 31. Date filed (Month, Day, Year) 32. Registrar's Signature 6188 Oxon Hill Road, #704, Oxon Hill, Maryland 20745

within 24 hours a To the Funeral C completely filled i

Medical

State

The law requires that the death certificate be executed Box 68760, Ö Δ. Division or Vital Records, or Attending after death Director: the filled in by

Baltimore, Maryland 21215-0036

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 medican sxaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one

29c. License number

D37588

29d. Date signed (Month, Day, Year)

April 5, 2007

n 24 hour. Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

225 Town Square Drive #2, Lusby, MD 20657 Rafik A. Nasr, M.D.

State Registrar

Medical

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thomas Lee Webb 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Federalsburg 409 West Central Avenue Caroline 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 1956 220-66-2678 May 11, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Maryland Caroline Federal sburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 West Central Avenue 21632 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 查查No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nagel Farm Service Raised Chickens & Grains 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Butler, Sr. Alfreda Webb Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 W. Central Ave., Federalsburg, MD 21632 Kim B. Webb/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or once, Federal Hill Cemetery 04/15/07 |Federalsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Muhail Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARELLOMA 30dn15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed

page 2 should

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ANO

					performed? 1□ Yes 2 2 N	death? 1 ☐ Yes 2
25. Was case referred to medical				26. Place of Death (C	Check only one)	"
examiner? 1 D Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)

7. Manner of Death	
1 ANatural	5 Pending
2 Accident	investigation
3 ☐ Suicide	6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Hole mo 29c. License number D26388 29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave Hurlock Md 21643 302 Collins Freeder Michae

State Registrar

Certification: To

Medical

32. Registrar Signature APR 1 6 2007

within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

42		1 - For State Registrar	State of Maryla		epartment of F Certificate of		ivientai Hy	/giene Reg. No.	000	7 128
Physic /Medi		1. Decedent's Name (First, Middle, La	ucile Wade				2. Date of D Month April	Day	Year 2007	3. Time of Death 4:37 A
Exami		4a. Facility Name (If not institution, give Caroline Home Lo	ve street and number)			or Location of Dea	ath	1	County of Death	
Funeral Director		5. Social Security Number 6. S		rs. last birtho	Months Days		s. 8. Date of B (Month, D	irth Jay, Year)	9. Birth	place (State or Foreig
D		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town o	r Location		nugust	17, 17		10d. Inside City Limits
the Mary 28a-f sh notified a	Director	Maryland Talbot 10e. Street and Number		Eas	ton 10f. Zip Code			10a Citi	zen of What Cou	1 ☐ Yes 2 ☐ No
th with 23a or 1st be r	al Dii	640 Mecklenburg	Avenue		2160)1		"		es of Amer
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ You If Yes, Give Year or Dates:	i U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Americ Black, White, Specify:	etc.
רסט 72 ה "natural edical בי	Completed t	15. Decedent's E (Specify only highest gr.	ducation	16a. De	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of w	orking	16b. Ki	nd of Business/In	dustry
should be filed within of Mental Hygiene. marked other than matic event, the Me	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		ertising So				Newspa	rer
1 be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last	") rison Johnsto	n			ame (First, Middle 2 Lucile		,	
2 should and Mer is marke aumatic	P	19a. Informant's Name/Relationship		111	lailing Address (Street			, ,		Code)
1 and 2 Health em 27 i		Nancy Hoeck 20a. Method of Disposition	Daughter		Box 65, Ro		, Maryla Date		662 cation - City or To	own State
0 U - 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Whemoval from State		isposition (Name of crematory or other pla) L Cremato A	1	11/2007		ver, Dela	
permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Lice			22. Name and Addre Moore Fune 12 South	ess of Facility		,		
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	lar	deme		ac or respiratory	arrest,		Approximate Interval Between Onset and Death
be executed sian and urial-transit										
cate L ohysic the b	9:									
the death certificate be y the attending physici ched for use as the bu	ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			23d. Date of deliv Month	ery Day Year
equires that the death certificate ben signed by the attending physicould be detached for use as the bould be detached for use as the bound be detached for use as the bound be detached for use as the bound be detached for use as the bound because	ed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown contributing to death but not	etal death of death	5 ☐ Other (specify) _	,		tobacco u	Month use contribute to t	Day Year he cause of death?
law requires that the d as been signed by the 2 should be detached	Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown Part II. Other significant conditions	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown contributing to death but not	etal death of death	5 ☐ Other (specify) _	,	1	tobacco u	Month use contribute to t PNo 3□ Proi 24b. Were aut	Day Year he cause of death? pably 4 □Unknov
law requires that the d as been signed by the 2 should be detached	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner?	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death of death resulting in th	5 ☐ Other (specify) _	ven in Part I. 26. Place of D	24a. Wa - aut per 1 Yes	tobacco u Yes 2 s an opsy formed? 2 No one)	Month use contribute to to the second of th	Day Year he cause of death? pably 4 □Unknow posy findings availab mpletion of cause of 2 □ No
ing Physician: The law requires that the d I. After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Fegnant at time of 9 Unknown contributing to death but not Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	etal death of death resulting in th E ER/Outpa 28b. Tim	S Other (specify) _ ne underlying cause give attent 3 DOA Ott ne of Wo M 1	ven in Part I. 26. Place of Der: 4 □ Nursing	24a. Wa per 1 Yes eath (Check only Home 5 Res 28d. Describe	s an oppsy formed? 2 No one) sidence e how injur	Month See contribute to to the see contribute to the see contrib	Day Year he cause of death? pably 4 □Unknow posy findings availab mpletion of cause of 2 □ No #OSPICE fy) #OSPICE
ing Physician: The law requires that the d I. After this certificate has been signed by the funeral director, page 2 should be detached	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 F4 4 Pregnant at time of 9 Unknown contributing to death but not Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year building, etc. (Special Place of Special Place of Injury etc.)	etal death of death resulting in th P ER/Outpa 2 Bb. Tim Inju t home, farm	other (specify) ne underlying cause give atient 3 □ DOA Other atient 28c. Injury M 1 □ n, street, factory, office	26. Place of Deer: 4 \(\text{Nursing} \) Nursing ry at rk?	24a. Wa autroper 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or To	s an oppy formed? 2 No one) sidence to how injure (Street an own, State)	Month See contribute to to the see contribute to the see contribu	he cause of death? bably 4 □Unknow posy findings availab impletion of cause of 2 □ No ##OSPICE ##ONE Al Route Number,
Hospital or Attending Physician: The law requires that the d 24 hours after death. Funeral Director: After this certificate has been signed by the stell filled in by the funeral director, page 2 should be detached	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1	etal death of death resulting in th P ER/Outpe 28b. Tim Inju t home, farm ecity)	atient 3 DOA Other (specify) atient 3 DOA Other of DOA Other of Months o	26. Place of Der: 26. Nursing ry at rk? I Yes 2 □ No Ime, date and pla opinion, death oc	24a. Wa per 1 Yes eath (Check only Home 5 Res 28d. Describe 28f. Location City or To	s an oppsy formed? 2 No one) sidence a how injur	Month se contribute to to the second	Day Year he cause of death? bably 4 □Unknow posy findings availab impletion of cause of 2 □ No #OSPICE fy) #OSPICE
ing Physician: The law requires that the d liter this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year building, etc. (Spink) 28e. Place of injury - A building, etc. (Spink) hysician: To the best of my miner: On the basis of examand manner stated.	etal death of death of death of death of death resulting in the resulting	atient 3 DOA Otter (specify) atient 3 DOA Otter of 28c. Injury Wo M 1 by street, factory, office death occurred at the tor investigation, in my 29c. Licen:	26. Place of Deer: 4 \(\text{Nursing} \) Yes 2 \(\text{No} \) No date and pla opinion, death occase number	24a. Wa auturer per 1 Yes eath (Check only Per 28d. Describer 28f. Location City or Toured, and due to the coursed at the time	s an oppsy formed? 2 No one) sidence a how injure (Street andown, State e cause(s) e, date and	Month See contribute to the see contribute	he cause of death? bably 4 Unknow posy findings availab mpletion of cause of 2 No fy) #OSPICE fy) #OSPICE al Route Number, stated. o the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 6, 2007 10:00p ^M <u>Virginia Christine Williams</u> April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bel Air If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Bir (Month, Day, Year) | 951 Upper Chesapeake Hospital Harford 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 55 DE 219-58-0442 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Harford Edgewood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2903 Pulaski Hwy. 21040 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>RN Nurse</u> Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) V. Allison Ott <u>George B. Powell</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theodore C. Williams/Husband 2903 Pure 20a. Method of Disposition 20b. Place of Disposition 20b. 2903 Pulaski Hwy., Eddgewood, MD 21040 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 10, North East Cemetery North East, 2007 22. Name and Address of Facility 21. Signature of Furleral Service Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter tV disease, or conclications that caused the death. Do not enter the mode of ying, such a circlad or restart failure. List only one cause on each line. Immediate Cause (Final 21-921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II/Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2√No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe es 2 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

alth and t

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other? Injury or other

death with the Maryland

Maryland 21215-0036

Baltimore,

0

201

M300

68760 367

Ö

ئے

Division or Vital Records,

burial-transit and been

g

Physician/Medical þ Completed Be Certification: To

4 ☐ Homicide

29b. Signature and title of dertifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1112

2007

Year)

29a. Certifier (Check only one)

Examiner

Hospital or Attending Physician; 24 hours after death. Funeral Director; After this certifice within 24 hours at To the Funeral D

> State Registrar

500

32. Régistrar's Signature

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Chesc

PALI

29d. Date signed (Month, Day, Year)

Be1 17,1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day LEATRICE HELEN YATES APRIL 14, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 🖫 F 234-36-7504 JUNE 11,1925 W.Va. Usual Residence of Deceden: 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits CHARLES NEWBURG 1 □Yes 2 □ No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13393 BEACH HAVEN CIRCLE 20664 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NSWC-DAHLGREN Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. DISPOSAL TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TOBITHA ELIZABETH PARKS JOHN DYE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA KORROW-DAUGHTER 13410 BEACH HAVEN CR. NEWBURG, MD. 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHRIST CHURCH CEM. 4-19-07 WAYSIDE, MD. 21. Signature of Juneral Service Licensee MQO479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES - 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown YPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

sician and burial-transit physician the Records, P.O.

Division or Vital

To the hosping within 24 hours after death.

To the Funeral Director; Af

Physician/Medical

þ

Certification:

Medical

Physician

/Medical

Examiner

Directo

ð

Completed

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other 1 once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

CHOLANGIO-CARCINOMA OF LIVER

29b. Signature and title of certifier MCD

29c. License number 29d. Date signed (Month, Day, Year) D 26064

04-14-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANMANGANDLA-VIDYASAGAR

10583 THEODORE GREEN BLVD WHITE PLAINS, MD-20695

State Registrar 31. Date filed (Month, Day, Year) APR 2 0 2007 Registrar's Signature

		_	1 - For State Ragistrar	State of M	larylan				lealth a	and M	_	giene	211111	12867
			Decedent's Name (First, Middle, La	st)							2. Date of De	ath Da	y Yeer	3. Time of Death
	Physicia /Medic		Bruno Zurad										007	2:10 A M
	Examin		4a. Facility Name (If not institution, giv	e street and numbe	r)				Location of	of Death			. County of Dea	th
			Vantage House 5. Social Security Number 6. S	Sey 7.4	ne /In vrs	last birthday)		olumb r 1 Year		24 Hrs.	8. Date of Bir		Howard	thplace (State or Foreign
	Funeral Director		328 01 8783	ISM 2□F	90	Yrs.	Months		Hours	Min.	(Month, Da Sept	y, Year)	C	llinois
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	ō	FT. Lee			ano Co	wa 7							1 ☑ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			ape Co		p Code				10g. Ci	tizen of What C	ountry?
	th wit	alD	4202 SE 4th Pl. 7	Apt.#E2			3	3904				USA		
	tems ren	Funeral	11. Marital Status	12. Was Deceder Armed Forces	:7	.S. 13.	Was Dece If Yes, spe	dent of H	ispanic Ori In, Mexican	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi	
21215-0036	hours after death with the Maryland tural; or Items 23a or 28a-f show al Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates		4-	1 🗆 Yes	2[X No	Specify:				Specify:	White
2-0	72	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	kind of w	ork done	during most	t of workin	ng	16b. K	(ind of Business	/Industry
121	within iene. then	mpi	Elementary/Secondary (0-12)	College (1-4o			DO NOT						1 0	
	filed v I Hygie other t		17. Father's Name (First, Middle, Last	4		Manage	r in	Мар			(First, Middle			vernment
Maryland	og at be ye	To Be	Joseph Zurad								Dudek			
lary	and and is m		19a. Informant's Name/Relationship (or Town, State,	Zip Code)
	s 1 and 3 f Health Item 27 other tra		John E. Zurad/son	<u>n</u>	205 5	9573 d					City,		21042 ocation - City or	Tour State
Baltimore,	of of the second		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		8	Place of Dispo cemetery, cres							-	
Iţ	그 든 원 근	1	* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices		Gar. 01442								ngs Mil	ily FH Inc.
Ba	Depa Impo any is		Vannin L	Radden	01442								tt City	
	e		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the deat line.	h. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DET	314	フソ								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consec	juence of):								
泰		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a consec	juence of):	-	_						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	STR	Olif	=								
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or a	s a conseq	quence of):								
3760,	5 × 6	Icai		d										
x 68	ertifica ding pl	Med	IF FEMALE:	220 If you system										
Вох	eath certificate attending phys I for use as the	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	Ectopic p		,			Ĩ	23d. Date of de Month	Day Year
o.	at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		10a(ii 3)	_ Other (s	pocity)						
ď.	es that igned b	by Pl	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause giv	en in Part I.	*	23e. Did t	obacco	use contribute I	to the cause of death?
ords	w require been sig should b										10	Yes 2	.□No 3□P	robably 4 Unknown
Records,	2 2 5	Completed									24a. Was auto	psy	prior to	utopsy findings available completion of cause of
						·						ormed? 2 XNo	death?	s 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:	4in =4 0 C	150/0.4		OA Oth			(Check only		0.1. (0.	
o	g Physer this	-	27. Manner of Death	1 ☐ Inpa 28a. Date of Ir	jury	ER/Outpatier 28b. Time o		28c. Injur	y at		ne 5 🗆 Resi 8d. Describe			ecityAsst. LVJ.
ion	r A P	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month, L</i> n	Day Year)	Injury	М	Wor 1 □	k? Yes 2□	No				
Division	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	289. Place of	njury - At h etc. (Speci	ome, farm, str fy)	reet, facto	ry, office		2	28f. Location (City or To	Street ai wn, State	nd Number or F e)	Rural Route Number,
۵	Hospite 4 hours Funerel	Medical Ce	29a. Certifier 1 To Certifying Pl (Check only 2 Medical Example)	nysician: To the beaminer: On the basis	of examina	owledge, deat ation and/or in	h occurre	d at the tir n, in my o	ne, date an pinion, dea	nd place, a	and due to the	cause(s date an	and manner a d place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		1		29	c. Licens	e number			29d. Da	ate signed (Mon	ith, Day, Year)
	~ 3 ~ ŏ		· CLIABO	ey n	0			053	98	7		179	Rell 9	17,2007
104	Das		30. Name and address of person who	completed cause of	death (Iter	п 23a) (Туре,	Print) K	EN	NETT	# 0	EHI	wi)	3.511
	Sta	t o	31. Date filed (Months, Pay, Year)	32. P. 615	strar's Signa	ature 7	11-6	IM	0166	- 1	00 2	16		
28	Sta Registr		APR 0'9	2007	SHC.	H.	Local							

ORIGINAL

Duane Lee Allen 07-02983 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner Duane Lee Allen April 18, 2007 1450 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2200 Block of Annapolis Road Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 220-90-4626 42 XXм 08/04/1964 Country) Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2XX No 28a-f show Baltimore Rosedale notified at once, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 Talister Court 21237 U.S.A. 23a Pages I and 2 should be filed within 72 hours after death with t nent of Heath and Mental Hygiene. auti. Filem 27 is marked other than "natural", or items 23a rother traumatic event, the Medical Examiner must be not 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Never Married 2 X Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2XWidowed If Yes, Give Year Yes 2 X No specify: Divorced Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Driver Com Trucking 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lester Allen Be or other traumatic event, Betty Newlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Allen (Wife) 48 Talister Court, Baltimore, Maryland 21237 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, Date 1 XBurial 2 Cremation crematory or other place) Removal from State portant: Holly Hill Mem. Gard. 04/23/2007 Baltimore, Maryland Donation Other Specify 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A na M Figueral Sandae Elcensed Old Eastern Avenue, Essex, Maryland 21221 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death Methadone and promethazine intoxication, cocaine use and dr wning Imme Vate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED the attending physician led for use as the burial #MENDED #23a,27-28a-f, perME, g867, 5/19/07 TT Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy Live birth Fetal death 3 Ectopic pregnancy Year past 12 months Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed ificate has been si r, page 2 should b Division of Vital Records, 24a Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ۵ 1 ✓ Yes No After 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natura Yes 2 X No Pending unk Fnd 4/18/2007 Fnd 2:40 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number. City or Jown, State) 2200 DIK OT ANNAPOLIS 6 X Could not be 3 Suicide creek determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month strar's Signature State Day, Year Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL CYNTHIA ANN ALIZADEH 2007 8:37 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 X F 215-76-4522 49 Director 1/2/1958 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Exercises 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE GLEN ARM 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24 GUNPOWDER ROAD Funeral 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME **YEARS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT C. ISELLA VIRGINIA J. PILKRNTON ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YAGHOUB B. ALIZADEH/HUSBAND 24 GUNPOWDER ROAD GLEN ARM, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 4/25/2007 PARKVILLE, MD 21. Signature J Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, a 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause by each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ovarion Concer 10 m ouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burstal-transit ompletely filled in by the funeral director, page 2 should be detached for use as the burstal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D0051926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 P. Charles & PPE 203 Baltimore MD 21204 M. Gordon MO

State Registrar 31. Date filed (Month, Day, Year)

APR 23

2007

DHMH 17 Rev 1/2001

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, 2 Date of Death 3. Time of Death 20-12:309M ainia exander 2007 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Baltimore Under 1 Year | If Under 24 yndhurst 5. Social Security Number If Under 1 If Under 24 Hrs. 8. Date of Birth Month Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) a Months Days Hours 1 □ M 2 XF 215-22-6305 Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No ti More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced blac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pather's mme (First, Mdde, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margare vintield. arker er or Rural Route Number, Çity or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 19b. Mailing Aurress (Street and Num Lee Daughter 21229 10.1 Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn, 4 Donation 5 Other (Specify) 21. Signature of Furgral Service Lifense 27 Greene Bathmore, MD 21220 more Natt 23a. Part 1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Metastatic cancer to bram, 4 mos disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery ☐ Ectopic pregnancy Month Day Year

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Funeral Director

Completed by

Be

٥

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 le marked other than "natural", or iteme 23a or 28a-f show ury or other traumatic event, the Medical Exacilinat relations to include traumatic event, the Medical Exacilinat relations.

Baltimore, Maryland 21215-0036

Maryland

Examine Completed by Physician/Medical Be ٩

executed use as the burial-transit physicien Hospital or Attending Physician: The law requires that the death certificate be ed by the e this Il Director: After this of in by the funeral d death. filled in by ë

Division of Vital Records. P.O. Box 68760.

Certification: within 24 hours after To the Funeral Direct Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐ Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 aurence Gallegir MI

31. Date filed (Month, Day, Year)

01

APRIL 23, 2007

Sain, MD mass

State Registrar

Anderson, Angel C.

68760,
Вох
P.0.
Records,
Vital
o
Division

									. Ensure A					
			For State Registrar	•	State of IVI	aryiand		artment of F rtificate of	lealth and I Death	vientai Hy	_		10	0 "7 1
			Negistrar Necedent's Name (First,	, Middle, Last)			001	incate or	Death	2. Date of De	Reg. No	2007	3. Time of	Death
	Physicia /Medic		Ange1	Ca11:	ie	Ande	rson			April	2 i		7 9:3	DAM
	Examin		4a. Facility Name (If not ins	- 1 1	0 00	11-			r Location of Death		4c	. County of Deal		
		- 12	Sinai Hos		, , -	eltim je (In yrs. las		If Under 1 Year	imore If Under 24 Hrs.	8. Date of Bir	th	O Pie	inniana (Ctata a	- Foreign
	Funeral Director		218-65-5669		vi 2 X ΣF	9	Yrs.	Months Days	Hours Min.	Nov. 2	iy, Year	Co	thplace <i>(Stat</i> e o. ountry) g inia	r Foreign
	pu ,		Usual Residence of Deced	lent County		100 City	Town or Lo	action			_, _			
	/anyla	ō		ltimore		Too. City,		ngs Mills	2				10d. Inside Cit 1 ☐ Yes	•
	r 28a-	Director	10e. Street and Number					10f. Zip Code	,		10g. Cit	tizen of What Co		
	th with 23a o 1st be	a D	1134 King	sbury R	oad			2	21117			U.S.A	•	
	er dea	Funeral	11. Marital Status		. Was Decedent Armed Forces?		13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by F	1 XX Never Married 2[3 ☐ Widowed 4 ☐ Di		1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		I□Yes 2√∑No	Specify:			Specify:	White	
215-0036	72 hou natura ical E	ted	15. De	ecedent's Educa	tion		16a. Deced	lent's Usual Occup	pation	liin -	16b. K	ind of Business/		
21	within 72 ene. than "nai he Medici	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L		during most of word d)	king				
22	d 2 should be filed within 72 hour th and Mental Hygiene. 7 is marked other than "natural traumatic event, the Medical E;	S	4 17. Father's Name (<i>First</i> , A	Middle Last)				Student	18. Mother's Nam	ne (Firet Middle	Maidar	Educat	ion	
Maryland	ld be i ental ked o ic eve	To Be	, ,	Michael	Anders	on			Linda	Jean	_	sner		
ary	should land Men s marker umatic	-	19a. Informant's Name/Re				19b. Mailin	g Address (Street	and Number or Ru				Zip Code)	
	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		Mr. & Mrs. J		erson Pa				y Road	Owings 1	Mill	s, MD	21117	
saltimore,	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Crem		noval from State	20b. Plac	ce of Dispo netery, cren	sition (Name of natory or other pla	ce)	Date	20c. Lo	ocation - City or	Town, State	
	permit. Pages Department of Important: If II any Injury or o		4 ☐ Donation 5 ☐ O			A11 S		Cemeter Name and Addre	C = 100			stersto		
g	Depart any l		0	her W		Kins			ERAL HOME			erstown own, MD	Road 21136	
Ŀ	_ >		23a. Part1. Enter the diseashock, or heart failure	ase, or complica	tions that caused	I the death.						own, in	Approximate Interval Betv	e veen
	Physician		Immediate Cause (Final disease or condition	a.		bral		~	ischen				Onset and D	Death
<i>!</i>	/Medical Examiner		resulting in death)		Due to (or as		rice oi).						00 1	
E.		ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e b	Due to (or as			rest Ci	esusci-	ratea			28 116	ders
	cuted nd ransit	Examiner	that initiated events	S C.	conqu	enita	ul m	yasthe	nie sy	ndror	ne		9 40	ars
og,	be executed sician and burial-transit	al Ex	resulting in death) Last		Due to (ot as	a consequer	nce of):)					1	
200	physic physic the b	dica		d										
POX	sician: The law requires that the death certificate certificate has been signed by the attending physrector, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregna	ant 23c	. If yes, outcome							23d. Date of del	iverv	
	death ne atten ed for u	sicia	in the past 12 months 1 ☐ Yes 2 🗷 No		1 ☐Live birth 4☐Pregnant at 9☐Unknown			Ectopic pregnancy Other <i>(specify)</i>	/			Month	Day Y	/ear
т Э	hat the	Phy	9 ☐ Unknown Part II. Other significant c	anditions contr		ut not reculti	ng in the un	dorlying course give	on in Bort I	220 Did t	obacco .	ing contribute to	the sever of d	41- 0
cords,	The law requires that the ate has been signed by the bage 2 should be detached.	d by	Tarrii. Other significant o	STIGHTONS CONTRO	bulling to death b	ut not resulti	ing in the un	denying cause giv	en in Parti.	1 🗆 1		use contribute to	othe cause of de obably 4 □U	
	s beer shou	Completed						-		24a, Was	an	24b. Were au	topsy findings a	available
ב ב	The la	mo:								autor perfo	osy ormed? 2. ✓ No	prior to death?	completion of ca	iuse of
N Ear	cian: ertifica ector, l	Bec	25. Was case referred to n examiner?						26. Place of Dear			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110	
20	Physic this c	P	1 ☐ Yes 2 No 27. Manner of Death	Hos	spital: 1 Minpatie 28a. Date of Inju		NOutpatient		4 LI Nursing H			6 □Other (Spec	cify)	
5	th. : After	tion	1 Natural 5 □ I	Pending investigation	(Month, Day	y Year)	Injury	28c. Injur Wor M 1 🗆	yai k? Yes 2 □ No	28d. Describe	now injui	ry occurred		
INISIOII	Atter er deal rector by the	Certification:	3 ☐ Suicide 6 ☐ 0	Could not be determined	28e. Place of inju	ury - At home (Specify)	e, farm, stre	eet, factory, office		28f. Location (3	Street an	nd Number or Ru	ıral Route Numl	ber,
5	ital or Irs afte ral Dir	Sel										·		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he Completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☑ Ce (Check only one) 2 ☐ Me	rtifying Physic edical Examine	ian: To the best of r: On the basis of and manner sta	r examinatioi	edge, death n and/or inv	occurred at the tire estigation, in my o	me, date and place opinion, death occu	and due to the rred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s))
	Fo the within 3	Mec	29b. Signature and title of	_				29c. Licens	e number		29d. Da	te signed (Monti	n, Day, Year)	
	- CT		Charle	the al	ekona	u,	MID	D4	7128		AD	ril 20	2007	-
	4		30. Name and address of p	erson who com	oleted cause of d	eath (Item 20	3a) (Type, F	Print)		101.				
	Cto		31. Date filed (Month, Day,		32. Registra	may H	ospita	l of Baltin	nore, 2401	w. belve	rese	Ave, Bal	timore M	1) 21215
	Stat Registra			R 2 3 20	07 120	CARL A	de A	Sarle	e number 17128 nore, 2401					
				- And 19 100 100 100 100 100 100 100 100 100	7 - 30 -	-	- 0 - 5					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Theodora Athanas 2227 Apri1 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 13 F 83 577-40-0522 December 26, 1923 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5901 Montrose Road, Apartment N-1306 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 'ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Pappadeas Stavroula Alexopoulos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Montrose Road, Apt. N-1306, Rockville, MD 20852 Thomas C. Athanas / Husband 20b. Place of Disposition (Name of cemetery crematory or other place).
Parklawn Memorial
Park April 20, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Rockville, Maryland 4 Donation 5 Dother (Specify) 2007 22. Name and Address of Facility Robert A. Pumphrey Funera Rockville Inc. 300 West Montgomery Avenue 21. Signature of Funeral Service Licenses Funeral Home/ M01433 Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final houmonia disease or condition Due to (or a consequence of): aflure. Due to (or as a densequence of) sepso e Due to (or as a consequence of) ementa. IF FEMALE. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mal hallahou No 3 Probably 4 Unknown 1 ☐ Yes . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA

Physician /Medical Examiner

attending physician and for use as the burial-trar

been signed by the should be detached

page 2 s has

director,

certificate

after death Director: / d in by the f

To the Hospius within 24 hours after To the Funeral Dir

Box 68760

o

Records,

Vital

ō

Division Hospital or Attending

THEODORA

ATHANAS

Examiner

Physician/Medical

þ

Completed

Be

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

ftems 23a or 28a-f show ner must be notified at

'natural", or items 23a dical Examiner must I

Baltimore, Maryland 21215-0036

1 and 2 should be filed w Health and Mental Hygier m 27 is marked other th

Pages '

or other train

permit. Page Department o Important: If any Injury or

Director

Funeral

þ

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of Death 1 Natural

29a. Certifier

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 THomicide

31. Date filed (Month, Day, Year)

14 Impatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)

Sjetrar's Signature

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

and manner stated. 29b. Signature and title

2007

29c. License number

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

6320 Devno Crey Blvd, 30. Name end address of 20877

State Registrar

APR 2 DHMH 17 Rev 1/2001

ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2007 April 9, **Physician** Baby Boy Blanton 11:53 AMM Baby C /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Hospital Baltimore 5. Social Security Number none 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 9, 2007 9. Birthplace (State or Foreign **Funeral** Hours 3 Months Days Country) Maryland Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 9 Sharonwood Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brendan Cavanagh Leslie Blanton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 Wolfe Street Baltimore, MD 21287 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Extreme Prematurity Due to (or as a consequence of): w 47 Muss Incompatible w /Medical Examiner gowth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760. Physician/Medical Cora IF FEMALE: lerai Director: After this certificate has been signed by the attendin filled in by the funeral director, page 2 should be detached for use. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို tal or Attending Pissafter death. 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t [🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WHE

APR 2.3

no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

North

Wa

egistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10023612

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 per dvr 8866 4-23-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year FONARA BARTUN APRIL 947 M 2007 /Medical Facility Name (If not institution, give street and number) Examiner City, Town, or Location of Death County of Death bi f Under eneral 24 Hrs. 0 OWAYC 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 227-22-1443 Usual Residence of Decedent 1 M 2 □ F Min. Director 2150 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No 1 na Ton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2420 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Race - Arrience... Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: MIT "natural" traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) + operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madgaline 1 20a. Method of Disposition item 27 Valley WIte 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 Removal from State Hills Mem. Gardens O Abingdon 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Shawn E. Wells 22. Name and Address of Facility tuneral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician espiratory allure /Medical Due to (or as a consequence f): Examiner bneumonia Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ H0 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9☐Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myocardial intarction 1 ☐ Yes 2 ☐ No 3 Probably 4 dunknown arlure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 22 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 2, 2007 D004366Z 0 30. Name and address of person who cause of death (Item 23a) (Type, Print) WILLAM BUY HOWARD CO GEN HOSP, CULUMBIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 20

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 13, Mary Elizabeth Burke 1:16 P M April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14635 Bauer Drive, Apt. 203 Rockville Montgomery 8. Date of Birth
(Month, Day, Year)
1017
2, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Pennsylvania 1 □ M 2 💢 F 166-16-6757 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location ns 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits Maryland 1 ☐ Yes 2 X No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14635 Bauer Drive, Apt. 203 20853 United States Funeral "natural", or Items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🛣 No 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Government permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important; If item 27 is marked other 1 any Injury or other traumatic event, the 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Burke Loretta Haggerty P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Martin Cerullo / Cousin 2117 Grand Avenue, Morton, Pennsylvania 19070 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 19. 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2007 Bethesda, Maryland 21. Signature of Funey Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 23a. Part1. Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Airway Disease Physician Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas page 2 autopsy performed? Yes 2X No certificate 1☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Hospital: Certification: To 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 🕅 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D06959 April 19, 2007 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Elba Martinez, M.D. 8808 Hidden Hill Lane, Potomac, Maryland 20854 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day BRANICH /Medical 2320 4,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHI he Johns HOPKINS If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. 1**⊘**M 2□ F 213-09-519K Director TTEMBEL9,19/4 VIA Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MID Director BA Hinor 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r UIS,A 145 2/202 633 N by Funeral filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIA-CK 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) th grade WATCHMAN DIFFERANT Companys None h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be mitchel Se Fusce BRANCI ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traconce. Bowelen YEAR! 313 BAITO. m) 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-21-07 remetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1129N. Chasing ST. BATTIONORS 23a. i art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** locardial hours /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Hypertension
Due to (of as a consequence of): burial-trar and Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Concer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Street Baltimore, Maryland 21287 (OV No! Registrar's Signature Hill 31. Date filed (Month, Day, Year)
APR 2 3 2007 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Diane ٧. Carlson ĭÿ 2007 рм 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson Baltimore Date of Birth (Month, Day, Yea Jan. 13, 5. Social Security Number If Under 1 Year If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Year) Months 1 □ M 2 X F Mary land 219-44-5489 Director 61 1946 Jan. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Md. Baltimore Baldwin Director 1 ☐Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any inJury or other traumatic event, the Medical Examiner must be nust be a "natural", or items 23a or USA 4905 Horse Hill Road 21013 by Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Budget Analysis** Johns Hopkins Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James G. Debelius Doris McDowell 2 19a. Informant's Name/Relationship (Type. Print) 19a. Informant's Name/Relationship (Type. Print)

Mr. Melvin O. Carlson, Jr./ Husb. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4905 Horse Hill Rd. Baldwin, Md. 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gdns. 4-23-07 Fallston, Md. 4 □ Donation 5 ☑ Other (Specife) ntombment 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Liousee 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician endo met inc concer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed? 2☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Iniury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Registrar

31. Date filed (Month, Day, State

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

6701

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

N. Charles St. Balts. Md 2120/

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Margaret M.	Costello
-------------	----------

			1- For State Registrar Ce		te of Deal		a wentan		leg. No.	200	17 128
E	Physici Exam			M	COSTEL			2. Date of Dea Month April 18, 2	ath Day Yea 2007	ar	3. Time of Death 2050 hrs
			4a. Facility Name (if not institution, give street and number) Saint Joseph Medical Center		4b. City,		Location of Dear	th	4c. County of Baltimor		nty
	Funeral Director		5. Social Security Number 213-82-6610 6. Sex 7. Age (In yrs. 1 M 2 XXF 46		day) If Und Month	der 1 Yea			Tth(MM/DD/YYYY 1-1960	E	
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town o	r Location						10d. Inside City Limits
	daryland 28a-f show any d <u>at once</u> .	jo	MD. BALTIMORE			TOW	SON				1 Yes 2 XXNo
	h the Mary 3a or 28a- otified at	l Director	10e. Street and Number 29 BELLOWS COURT		10f. Zip		204		10g. Citizen of Wh	S. A	Ť
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XXNever Married 2 Married Armed Forces? 1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year	i.S.		ify Cuba	spanic Origin? (\$ n, Mexican, Puert		White	e, etc.	an Indian, Black, WHITE
	ours afi atural' xamine	d by	15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual	Occupa	tion (Give kind of		Specify: 16b. Kind of Bu	siness/In	dustry
900	vithin 72 h ene. er than "n Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS	dı	BROKER	rking life	e. DO NOT use re	tired)	MORTG	AGE	
215	oe filed v ntal Hygi ked oth	Be Co	17. Father's Name (First, Middle, Last) WILLIAM C.	CO:	STELLO			ie (First, Middle, THLEEN	Maiden Surname)	_
24	should I and Mer 7 is mar	5	19a. Informant's Name/Relationship (Type, Print) KAREN C. JENKINS (SISTER)	19b.	Mailing Address		et and Number or	Rural Route Nu	mber, City or Tow		
2	I and 2 Health item 2 r traum		20a. Method of Disposition 20b.	Place of	Disposition (Na	me of ce		Date	E, MARYI		
	Pages ment of tant: If		4 Donation 5 Other Specify:	T.JOS	SEPHS CH	i.CEI		-23-200	FULLE	RTON	,MARYLAND
a For	permit Depart Impor injury		21. Signature of Funeral Service Licensee (R. G. RUTH)			rows	ON FUNER		, INC. T_0		YORK ROAD N,MD.21204
	'vsician ledical		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not	enter the mode	of dying	, such as cardiac	ог respiratory ar	rest, shock, or hea	art	Approximate Interval Between Onset and Death
•	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of							-	Death
		Jer	Sequentially list conditions, if any leading to immediate		sease						
	d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	of):							
	cate be executed physician and the burial - transit	Medical E	dd				<u> </u>		<u> </u>	:	
760	ficate be ex g physician the burial		IF FEMALE: 23b. Was decedent pregnant in the	папсу					23d. Date of		
Roy 68	ne death certific the attending pred for use as the	hysician	past 12 months? 1	eath 5	Fetal death Other (Spe		Ectopic pregr	ancy	Month	Da	ay Year i
	res that the signed by the	by P	Part II. Other significant conditions contributing to death but not re	esulting i	in the underlying	g cause (given in Part I.				he cause of death?
of Vital Records P.O.	e law requir e has been s e 2 should l	Completed						24a. Was auto perfo	psy p		opsy findings available ompletion of cause of
Re PR	cian: The certificate ector, page		25. Was case referred to medical			26.Place	e of Death (Check	1 Yes	2 No 1	✓ Yes	2 No
Žį.	hysicis r this ce al direc	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V		patient 3	DOA	Other Nurs	ng Home 5	Residence 6	Other:	
on of	uding lath. r: Afte he funer		27. Manner of Death 1	28b. Tii	me of Injury		ry at Work? Yes 2 No	28d. Describe	how injury occurr	ed	
Division	ospital or Attending Physician: The law requires that the death certificate hours after death. Uneral Director: After this certificate has been signed by the attending by filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At h	ome, farr	m, street, factory	, office t	ouilding, etc.	28f. Location (or Town,		er or Rur	al Route Number, City
	To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a and manner stated.								
	F 3 F 8	Me	29b. Signature and title of certifier	-	29	c. Licens	e number		29d. Date sign	ed (Mon	th, Day, Year)
,	T		30. Name and address of person who completed cause of death (Item	0 2201		O.C.	M.E.	_	April 19, 20	007	
2			Tasha Greenberg MD. Assistant Medical Exam	,	111 Penn S	street,	Baltimore, M	D 21201			
	St		31. Date filed (Month, Day, Kebi) 7 3 / (32. Registrar's Signak	ле 🥕	Par Contract	6.0					

			_ Stata	tate of Marylan		artment of H			211	07	12879
_			Ragistrar 1. Decedent's Name (First, Middle, Last)		00,	incate of i	Dealit	2. Date of Dea	Reg. No:		3. Time of Death
	Physicia	an	Nelson Kennel	(00000	10			Month	Day	Year	IQUE M
	/Medic		4a. Facility Name (If not institution, give street	ot and number)	07.	4b. City, Town, or	r Location of I	Death Death		unty of Death	1773
	Examin	er	BROCKE CHLOUE REHABILIT		SING-	SAUDI	1 SP	RING		UNTGO	MERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24		h	9. Birthpl	ace (State or Foreign
	Director		165-12-1210 ¹™	^{2□ F} 84	Yrs.	Months Days	Hours	Min. (Month, Day Aug 25	, 1922	2 Mary	
	0		Usual Residence of Decedent								
	nylan how		10a. State 10b. County		y, Town or Lo	cation				10	d. Inside City Limits
:	Ma -t	cto	MD Montgome	ry	Olney						1 ☐ Yes 2 No
	다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다	ire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	ry?
	death with the Maryland ms 23a or 28e-f show mant be notified at	Funeral Director	4518 Winding Oak D	rive		2083	2		U.9	5.A.	
	dea dea	ner	11. Marital Status 12.	Was Decedent Ever in U Armed Forces?	.S. 13. V	Was Decedent of H	lispanic Originan, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. [Race - America Black, White, e	
2	afte or it	五		l⊠Yes 2 □ No WW lfYes,Give	11	1 ☐ Yes 2 ☑ No	Specify:		1		ite
3	ure!',	d by		Year or Dates:							
h	filed within 72 hours after Hygiene. Hygiene. uther then "naturel", or Ite and Ite Medical Exaction	Completed	15. Decedent's Education (Specify only highest grade co	on mpleted)	(Give	lent's Usual Occup kind of work done	during most a	f working	16b. Kind o	of Business/Ind	ustry
7	Per Sthir	ם	Elementary/Secondary (0-12)	College (1-4or 5+) 2		DO NOT use retired	•	± С1	0:		
7	tygie her t		17. Father's Name (First, Middle, Last)		ACCE	ountant/A		T DEC'Y Name (First, Middle,	Oj Maidan Sua		
	at to be	Be	Nelson K.	Cooper, Si	•		Jul			Kelly	
	should be filed within 72 hours after death with the Marylan and Mental Hygiene. In a marked other then "naturel", or items 23a or 28e-f show umatic svent, the Medical Exacilizar marks to territied at	၉			-					7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Cardal
	12 st h and 7 Is n treun		19a. Informant's Name/Relationship (Type, Mildred A. Cooper-w.					or Rural Route Numbe	1 11 11 11 11		Code)
บ้	1 and 1 and		20a. Method of Disposition		And the second second second	sition (Name of	Uak D	r., Olney,		20832 on - City or Tov	an State
2	Pages nent of h int: If fu		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	emetery, cren	natory or other place					
	tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)	1	ulaney			/24/07		nium, M	
0	permit. Pages 1 and 2 should be Department of Heaths and Menta Important: If item 27 Is marked any injury or other traumatic av 000cm.		21. Signature of Funeral Service Licensee	Jilliam G. [Name and Addres	ss of Facility	Ruck Towso Towson, MD	n Fune 2120	eral Ho M	me, Inc.
			23a. Part1. Enter the disease, or complicati	ons that caused the deat							Approximate
١,	Maria de Carta de Car		shock, or heart failure. List only one c Immediate Cause (Final								Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) a	Due to (or as a conseq						1,	DAYS
	Examiner			GANGRE		TOOT				ü	UFFILE
		ē	if any, leading to immediate	Due to (or as a conseq		001					
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ERIPHE.	RAL	VASCL	LAR	DISE	45E	V	EARS
,	exec n an	Exa	resulting in death) Last	Due to (or as a conseq							
8	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	dical	L d								
0	ificat g phy as the	edic									
Š	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me		f yes, outcome of pregna					23d.	Date of deliver	ry
	death e ette d for	icia	in the past 12 months?	1□Live birth 2□Feta 4□Pregnant at time of d]Ectopic pregnancy] Other (s <i>pecify)</i>	<u>'</u>			Month	Day Year
į .	by the	hys	9 □ Unknown	9 Unknown							
r.	s tha		Part II. Other significant conditions contrib		ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
	quire n sig uld b	Completed by	ADVANCED VA	SCULAR	DEL	LENTH	8	101	res 2	o 3∏Proba	ably 4 Unknown
ပ္သ	s bee	jet						24a. Was		4b. Were autop	sy findings available
ב ב	he la e ha: age 2	Ĕ						autop perfo	rmed? 2 No	prior to condeath?	pletion of cause of
ָ פּ	rsicien: The law s certificate has t lirector, page 2 s		25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		OF Place o	1 ☐ Yes f Death (Check only o		1 🗆 Yes	2 No
>	s cert	To Be	examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth		ing Home 5 ☐ Resid		Other (Specific	·i
ō i	a Phy erthi		27. Manner of Death	8a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur	y at ·	28d. Describe f			/
5	th. After	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆	K? Yes 2 ∐ No	,			
INISION	Atta	E C	3 ☐ Suicide 6 ☐ Could not be	8e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S	Street and Ni	umber or Rural	Route Number,
5	s afte	Certification;	4 Homicide	building, etc. (Specif	y /			City or Tou	ni, Statė)		
	ospit hours unsre ly fille		29a. Certifier 1. Cartifying Physicia (Check only 2 Madical Examinar:	n: To the best of my kno	wledge, death	occurred at the tin	ne, date and	place, and due to the	cause(s) and	manner as st	ated.
	To the Hospital or Attending Physicien: The I within 24 Hours after death. To the Funstel Director: After this certificate ha completely filled in by the funeral director, page	ledicai	one)	and manner stated.	on and/or m						
	Yeith To T	Σ	29b. Signature and title of certifier			29c. Licens				gned (Month, L	
	-		My Mo	ATTENDING	- PHYSI	CIAN D	4201	16 1	4PRIL	20,2	007
ار	+17		30. Name and address of person who comp GRAFE BLOOKE HUFFMAN 31. Date filed (Month, Day, Year)	eted cause of death (Item	n 23a) (Type,	Print)					
4	1 (GRALEBROOKE HUFFMAN	M-D181005	SLADS	Kingalk	cAO S	Andy SPRI	NGN	VARYLA	109800 ans
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	Ache les			I			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Year **Physician** Knne lise M 2007 6:26 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Peb. 13, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛛 F Germany Yrs 84 Director 218-70-1039 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 ☑ No "natural", or items 23a or 28a-f st dical Examiner must be notified Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 10001 Windstream Drive Apt#1004 21044 Germany Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper American Red Cross 1 and 2 should be filed wi lealth and Mental Hygien om 27 is marked other th Department of Health and Mental Hygin Important: If item 27 is marked other eny injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Köhle Anna Helmer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10001 Windstream Dr. Apt#1004 Columbia, MD 21044 (Husband) John B. Cataldo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4-19-2007 Metro Crematory Catonsville, MD Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licenses tackma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Cerebrovascular **Physician** 000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 Mellitus Diabetes 3 Probably 4 □ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate has 1∏ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation or Attending 1 Natural Injury // c.
// s after dea.
// al Director: After have the five 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier D37013 Interny D who completed cause of death (item 23a) (Type, Print) 11055 Little Potrant Plany Clubians 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav **Physician** Year MARY 11:23 PM D. COZART APRIL 2007 19 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GOOD SAMARATIN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F Yrs. Director 246 52 3126 74 MAR.31,1933 N.CAROLINA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show at r 28a-f sh notified 1 ☐ Yes 2 ☐ No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 6117 GLENOAK AVENUE ral", or Items 23a Examiner must b 21214 death \ by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xlo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or ther any Injury or other traumatic event, the Medical Framina 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH BAKER MARRIOTT CORP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HARRINGTON CLARA MCmillan 2 19a. Informant's Name/Relationship (Type. Print) JACQUELINE COZART (daughter) 6117 GLENG 20b. Place of Disposition (Name of cemetery, crematory or other place) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6117 CLENOAK AVE BALTO, MD 21214 Disposition /Name of Date 20c. Location - City or Town, State 20a. Method of Disposition GARRISON FOREST VET. CEM. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B.SCRUGGS FUNERAL HOME 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. . PRESTON ST. BALTO, MD Approximate Interval Between Onset and Death Immediate Cause (Final SEPS 1S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) been signed by the s should be detached I ☐ Yes 2. 1 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by (CONVICAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No TAGE RENAL 24a. Was an has te 2 autopsy page performe certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1⊠Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

APR 2 3 2007

nemales Klyne

29b. Signature and title of certifier



39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOXANUTE MICHEL BOW) 0 - GOOD SAMMANITAN MOSPITAL

29c. License number 255000 29d. Date signed (Month, Day, Year)

5601 LUCHRAVON

4/19/2007

			For Stete Registrar	State of Maryland	-	artment of H		Mental I	Hygiene Reg. No	1001	12882
	Physicia	an	1. Decedent's Name (First, Middle, Last)	LER DRA	V18			2. Date o		Year	- 1110 - 11M
	/Medic Examin		4a. Facility Name (If not institution, give s		noe	4b. City, Town, o	r Location of Death	10 1	~~~	County of De	
	_ Admin	Ŭ.	HOLY CROSS H	OSPITAL		SILVER	SPRIN				OMERY
	Funeral		5. Social Security Number 6. Sex	M 2DF	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month	i, Day, Year)		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	61	113.			102	0919	MCP	N hat
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Ba-fe	ctor	MD MONTGOT	MERY SIL	VER		26				1 ØYes 2 □No
	with th	Director	10e. Street and Number			10f. Zip Code	0.01.			izen of What (Country?
	deeth with the Maryland ma 23a or 28a-f ehow r must be ricklified at	Funeral		LUMBIA PIKE 12. Was Decedent Ever in U.S	#190°		904 Hispanic Origin? (S	pecify Yes o		14. Race - Arr	nerican Indian,
	riter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			Hispanic Origin? (S an, Mexican, Puert	o Rican, etc	.)	Black, Wh	
215-0036	n 72 hours after deeth with the Marylan "natural", or itema 23a or 28a-1 show edical Examinar must be mulified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐Yes 2☑No	Specify:				HITE
7	"natu	lete	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occup kind of work done	oation during most of wor d)	king	16b. K	ind of Busines	s/Industry
71.	filed within Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ZHNI CI			e	lectric	ca1
2		BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Mi			
<u>la</u>	should be ind Mental in marked c	To B	Harry Keller Dr	ane			Elea	nor G	ıy		
Maryland	C1 00 -= 00		19a. Informant's Name/Relationship (Ty	_		_	and Number or Ru			-	
	s 1 and f Health item 27 other to		HOLY CROSS H			sition (Name of	CIEN KI	Date			10 20910 or Town, State
Ö	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Qther (Specify)	lemoval from State		natory or other pla	сө)				
Baltimore,	permit. Page Depertment important: It any injury o	1	21. Signatur Funeral Stryice Licens		S 1	2. Name and Addre	ess of Facility Comy Board	1 655	W Ba	ltimore	Street
<u>n</u>	88 38		1 /mul	Leve	Ba	ltimore,	MD 2120)1			
			23a. Part Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not ent	er the mode of dyi	ng, such as cardiac	or respirate	ory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	CEREBRY		MON	A				IWERK
	/Medical Examiner			Due to (or as a consequence). CARDING		D R R CT					INSEK
		er	if any, leading to immediate	Due to (or as a consequ	ience of):	~1~~~1		,			(40 CE.1
	be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	CORONAR		7RTER	Y DIS	ZAS	8		1 YEAR
Ď,	be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as a consequ	ience of):						
8760,	physic the p	dicai		d							
×	death certificate e attending phys d for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar						23d. Date of c	delivery
. Box	death e atter	Physician/Med	in the past 12 months?	1 Live birth 2 Fetal		.]Ectopic pregnand] Other (specify) _	<u>.</u>		_	Month	Day Year
J Ö	at the de by the a	hys	9 🗆 Unknown	9□Unknown		Over China					
	The law requires that the te has been signed by the has been signed by the age 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not resu	alting in the u	nderlying cause gr	ven in Part I.		Diditobacco 1 ☐ Yes 2		to the cause of death? Probably 4 Dunknown
Records,	s been s shoul	Completed							Was an	24b. Were	autopsy findings available o completion of cause of
		E O							autopsy performed? es 2 2 No	death	? . /
/Ita	sician: 1 certificel rector, p	Bec	25. Was case referred to medical examiner?			100	26. Place of Dea	ath (Check o	only one)		
6	Phys this al dii	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatier	IL SLIDOA	her: 4 Nursing H		Residence		pecify)
5	ding After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2∏No	204. 5000		ny cooonica	
Division of Vital	r Attending er death. irector: After by the funer	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office			ion (Street a		Rural Route Number,
ā	0 = G =										
	To the Hospital within 24 hours e To the Funeral I completely filled	dical		vician: To the best of my knowner: On the basis of examinal and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/ ^		29c. Licen	se number		29d. Da	ate signed (Mo	onth, Day, Year)
			Dul	Wings	re	12	3805		00	1 13	2007
			30. Name and address of pers in who ca				2				100.5
			31. Date filed (Month, Day, Year)	OW MD 140 32 Registrar's Signa	DO FO	REST GI	EN RD S	LUER	SPRIM	16 WZ	010010
	Sta Registi		APR 2 3 20	32 Registrar's Signa	× A	and I					

			1 - State Registrar	State of	Maryland / D	epartmer Certificat				giene 0 0	7	12883
			Decedent's Name (First, Middle, Las	')					2. Date of Dea	ath		3. Time of Death
	Physici		WAYNS F	DRAN	C-E				Month	12 9	Year	1007 AM
	/Medic Examir		4a. Facility Name (If not institution, give	street and numi	ber)	4b. City	Town, or	Location of Death		4c. County o	f Death	
			MCIH			HA	4F	2570W	2	WAS	2411	VGTON
	Funeral		Social Security Number 6. Se	x 7 ZM 2□F	. Age (In yrs. last birth	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthpl Coun	lace (State or Foreign itry)
	Director		213-28-9723	4 2 d .	76 [*]	rs.			Oct 17	, 1230	Miss	souri
	land		10a. State 10b. County		10c. City, Town	or Location					10	0d. Inside City Limits
	Mary -f eh	to	MD Washing	on	На	gersto	v n					1 ☐ Yes 2√2 No
	r 28g	Director	10e. Street and Number				Code			10g. Citizen of WI	nat Coun	try?
	th wit	a	18600 Roxbury Roa	ad				21746		USA	A	
	r dea	ner	11. Marital Status	Armed Ford		13. Was Dece If Yes, spe	dent of Hi	spanic Origin? (Sin, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Race Black	- America , White, e	
36	be filed within 72 hours after death with the Maryland hat Hyglene. Id other than "natural", or Iteme 23a or 28a-1 show of other than "natural" to recitified at event, tre Medical Examinar must be recitified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give		1 🗆 Yes	2 🔯 No	Specify:		Specify:	wh	ite
Ş	hour	ed b	15. Decedent's Ed	Year or Dat		Decedent's Usu	al Occupa	ation	unk	16b. Kind of Bus	iness/Inc	_{dustry} unk
15	nin 72 n na	Completed	(Specify only highest grade			Give kind of we life. DO NOT	ork done d	turing most of wor	king UIIK			ulik
212	d with	mo;		nk	101 34)							
덛	al Hy al Hy soth	Be C	17. Father's Name (First, Middle, Last)			1	unk	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	unk
yla	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. ie marked other than "natural", or iteme 23e or 28e-f show aumatic event, the Medical Examinar must be ricitied at	ပ			,							
Maryland 21215-0036			19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing Addres	s (Street a	and Number or Ru	ral Route Numbe	er, City or Town, S	tate, Zip	Code)
	ges 1 and 2 t of Health if item 27 or other tr		MCI Hagerstown 20a. Method of Disposition			18600 R Disposition (Na		ry Road	Hagerst Date	own MD		
Baltimore,	Pages nent of th int: if its iry or of		1 Burial 2 Cremation 3		pate cemetery	, crematory or	other plac	θ)		200. Location	my or to	m, date
틀	it. Partmer		* 4 □ Donation 5 ▼ Other (Specify		ate	22 Name a	nd Addres	e of Facility				
Ba	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Liona Rona n	wade 1	irector	4				Baltimo	re S	treet
			23a. Part i Enter the disease, or comp	lications that car	used the death. Do no	Baltim ot enter the mo				rest,		Approximate
	Physician		shock, a heart failure. List only of immediate Cau (Final	0.3	2000-00000	CA	619					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	u.	r as a consequence o	f):	1					
	Examiner		Sequentially list conditions,	b. ———								
	D ==	iner	if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of	f):						
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence o	f\·					_	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	a E			. 45 4 50.155445.155 5	.,.						
687	ficate phys	edical		d								
Box	death certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	•				23d. Date	of delive	ory
m.	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregna	th 2 Fetal death nt at time of death	3 □Ectopic p 5 □ Other (s				Mon	th	Day Year
P.O.	that the de ad by the detached	hys	9 🗆 Unknown	9□ Unknov								
Ś	res tha igned be del	þ	Part II. Other significant conditions co	entributing to dea	th but not resulting in	the underlying	cause give	en in Part I.				ne cause of death?
ord	w requir been si should	ted							*	res 2□No 3	3 Prob	ably 4 Unknown
ec	has b	Completed							24a. Was autor	osy pr	ere autor for to consath?	psy findings available mpletion of cause of
<u> </u>	r. Th								1 ☐ Yes			262 No
Ë	Physicien: The raths certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe Othe	26. Place of Dea				INFIRMAN
Division of Vital Records,	Physic rules aral dis	To :	Yes 2 No 27. Man ler of Death	1 ☐ In	Injury 28b. Ti	me of	28c. Injury Work	4 Nursing n	ome 5 Resident	dence SQOther	. , ,) 1101 (1-(1)
ion	nding th. r: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year) In	jury M		C? Yes 2 □ No				
<u>S</u>	or Attending after death. Director: After in by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be determined	200. Place C	of Injury - At home, faring, etc. (Specify)	m, street, factor	y, office		28f. Location (S City or Tox	Street and Numbe	r or Rura	l Route Number,
ā	tal or A	Certification:	Tiomodo	- Daniem	g, etc. (<i>opocity</i>)				0.0, 0.70			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page			iner: On the bas	est of my knowledge, sis of examination and							
	To the h within 24 To the f	Medical	29b. Signature and title of certifier	and manne	er stated.		c. License			29d. Date signed		
)	To To		AA A A	Λ		23	7	10 633	8-2	April	10	9-027
			30. Name and address of person who	completed cause	of death (Item 22a) (Type Print\			3		10	000-
			PA FESIA	UA UN	C MC		MAC	FRST	UWn1	MD 9	777	47
	Sta	ate	31. Date filed (Month, Day, Year)	1.659	nietrarie Cionaturo	0-0-	, ,,	(-)	101	•		1
	Regist	rar	APR 2 3 200	Men	gistians signature	1842						

			1 - For Amend 29c, pering	State of M DVR, G866, 4	laryland / Dep /23/07 TT Ce	ertificate of	Health and <i>Death</i>	Mental Hyg	iene	07	12884
			1. Decedent's Name (First, Middle, La					2. Date of Deat	h		3. Time of Death
	Physic		BLAIR W	ILLIAM		DONOH	UE	April	Day 20	Year O 7	7:15 PM
	/Medi Examir		4a. Facility Name (If not institution, gi	ve street and number	r)	4b. City, Town,	or Location of Dea		4c. County		
	LXaiiii	iei	THE JOHN'S 140	PIZINS H	OSPITAL	BA	LTIMOR	E CITY			
	Funeral				ge (In yrs. last birthda)) If Under 1 Year	If Under 24 Hrs	s. 8. Date of Birth	1	9. Birthr	place (State or Foreign
	Director		220-30-0546	1 M 2□F	7) Yrs.	Months Days	Hours Min	July 16		Сош	yland
			Usual Residence of Decedent					Joury 10	, 1700	IIII	Jana
	ylan		10a. State 10b. County		10c. City, Town or I	_ocation				1	10d. Inside City Limits
	Mar Har	ţō	MD		Baltim	ore					1 Yes 2□No
	1 the	rec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	3a o	0	1 Chancery Squar	re			21218		111	SA	
	Jeath 2	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S. 13	. Was Decedent of		Specify Yes or No- rto Rican, etc.)			can Indian,
10	fler of	Ē	1 ☐ Never Married 2 ☑ Married	Armed Forces	?] No	If Yes, specify Cub	oan, Mexican, Pue	rto Rican, etc.)	Bla	ck, White,	etc.
9	ol', o	Þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	-	1 ☐ Yes 2 🎇 No	Specify:		Specif	y wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-1 ehow he Medical Exercine for conflied at	Completed	15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of B	usiness/ln	dustry unk
2	7 uin 7	pie	(Specify only highest gi Elementary/Secondary (0-12)	rade completed) College (1-4or	life.	e kind of work done DO NOT use retire	during most of word d)	orking			unk
7	Jene Transfer	E	12	4		gineer					
	othert,	Be C	17. Father's Name (First, Middle, Las	1)		B+WCCT	18. Mother's Na	me (First, Middle, I	Aaiden Sumar	ne)	
a	id be Med to ic €	To B	Elvin Donohue				F10	ie Turner			
Maryland	Shound M	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Stree		TE TOTTIET Nural Route Number		State, Zip	Code)
Ž	alth a		Carolyn Donohue	spouse	1 Ci	nancery S	duare Ra	ltimore,	MTV 919	2.1.33	
ā,	Hea Hea tem othe		20a. Method of Disposition	-	20b. Place of Disp	osition (Name of			MD 212 20c. Location		own, State
ō	ages int of t: If i		1 Burial 2 Cremation 3		cemetery, cre	ematory or other pla	ice)			Ť	
Baltimore	it. P intme inten- injuri	1	4 ☑ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		/ III.	22. Name and Addr	oce of Equility				
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: if item 27 is marked other than "nature!; or iteme 23a or 28a-1 ehow empty righty or other treumatic event, the Mudical Examt are must be notified at once.		Ronald S.	Wade Dir	ector	State An	atomy Bo	1201 655 W	. Balt	imore	Street
			231. Part1. Inter the disease, or con	n ications if at cause	ed the death. Do not er						Approximate
			shock, ir heart failure. List only Immediate Cause (Final	one cause on each	line.			^			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Courd	ievas cular sa consequence of):	Collaps	e and	Kypote	noion		1 day
п	Examiner			Due to (or a	1 4 4						2 1
		-	Sequentially list conditions,	b. Due to (or a	s a consequence of):	acidosis				-	3 days
	ted nslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	3	0 2 0						r 1.
	icate be executed physicien and s the burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):	-0					3 days
8760,	be e			1	٨						16 years
87	phys the	dicai	•	d. Ly h	phome						10 Jears
9 ×	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	220 If you system	a of programmy					-	
Вох	ath o	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	;y			ite of delive onth	ory Day Year
	the c	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death 5	Other (specify)					,
P.O.	that the ded by the detached	P.	Part II. Other significant conditions		.			00- 014			
ŝ	signed by det	þ	ratti. Ottor significant conditions	contributing to death	but not resulting in the	underlying cause gi	ven in Pan I.				he cause of death?
50	w requir been si should	ted					-	1 Ye	s 2 No	3 LI Proc	pably 4 Unknown
of Vital Records,	hes by	Completed by						24a. Was a		Were auto	psy findings available impletion of cause of
<u>ح</u>	The cate he page	P.O.						perform	ned3/	death?	
ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical				26. Place of De	ath Check only on	THE RESERVE TO SERVE		
>	ysician: is certific director,	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 ER/Outpatie	ent 3 DOA	her:	Home 5 ☐ Reside	nce 6 □Oth	ner (Specif	iv)
0	iding Phy th. After this funeral o		27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injury	of 28c. Inju		28d. Describe ho			.,
0	uttendin death. ctor: Aff y the fur	atto	1 □Natural 5 □ Pending 2 □ Accident investigation		ay roar, injury		Yes 2 No				
Division	Attencer death	il ic	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of it	njury - At home, farm, s	treet, factory, office		28f. Location (St.		oer or Rura	al Route Number,
Ö	alor A s after il Direct	Certification:	4 Nomicide	building, e	etc. (Specify)			City or Town	, State)		
	hours hours inere		29a. Certifier 1 Certifying P	hysicien: To the bes	t of my knowledge, dea	th occurred at the t	me, date and plac	e, and due to the ca	use(s) and m	anner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical	(Check only 2 Medical Exe	miner: On the basis and manner s	of examination and/or i	nvestigation, in my	opinion, death occ	surred at the time, da	ite and place,	and due to	the cause(s)
	To the comp	W	29b. Signature and title of certifier		0 0	29c. Licen	se number	25	d. Date signe	d (Month,	Day, Year)
			(Raled el She	MD O	realogy fel	10W D6548	6		Pone	18 7	007
			30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)			110	16, 4	- 0 +
				THAM!		06 Nort	n Wolfe	Street,	Baltin	ore 1	4D 21287
	Sta	ate	31. Date filed (Month, Day, Year)	Regis	trar's Signature		V				
	Registr		APR 2 3 20		Me Ru	ASO P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Mildred Deering April 16, 11:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director 218-34-2119 81 Nov 13, 1925 Mary land Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 ☐ Yes 2 No Director Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Malvern Avenue 21204 Be Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Maryland 21245-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Joseph Foley Sr Mildred Heuisler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Patrick Deering/spouse 1001 Malvern Road Ruxton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) icensee Wade 21. Signatur Funeral Servic State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease or con , or heart failure. List only 23a. Part or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Hepatoma upara /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the burial Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 1 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 Yes 2 🗆 No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the it 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and menner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

Deering,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AI MEE Wheath MO 6701 N. Charles St. Balt MO

2. Registrar's Signature

I mee Wheaten MD

APR 2 3 2007

31. Date filed (Month, Day, Year)

D58639

peil 16,2007

			1 - For State Registrar		State o	f Maryla		oartmer e <i>rtificat</i>				nental Hyg	giene Reg. No.	007	12886
	Physici	an	1. Decedent's Name (First, M	iddle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Media	cal	William K. Do			()		4 03	-		(5 1)	April 1	1		9:05 AM M
	Examir	er	4a. Facility Name (If not institu					4b. City,		Location	of Death			inty of Deat arford	
	Funeral		Upper Chesape 5. Social Security Number	6. Sex			er rs. last birthda	y) If Unde	1 Year	Air If Under		8. Date of Birt	h	9 Birt	holace (State or Foreign
	Director		189-12-2828	11	M 2□F	84	Yrs.	Months	Days	Hours	Min.	Nov 9,	1922	Mar	y land
	p ,		Usual Residence of Deceden			140-	0.4					-			
	anyla ehov	<u>_</u>	MD Ha	nny rford		100.	City, Town or $Be1$								10d. Inside City Limits 1 ☐ Yes 2\☐ No
	the M	ecto	10e. Street and Number	LIUIU			DET	10f. Zig	Codo				10g. Citizen	of Mhat Ca	•
	th with the Marylan 23s or 28s-f show	<u>a</u>	1008 Leeswood	Road	l			101. 21	70000	210	14		rog. Omzon	USA	unity:
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow dical Examinan must be notified at	Funeral Director	11. Marital Status		12. Was Dece	edent Ever in	U.S. 1	3. Was Dece	dent of Hi			ecify Yes or No- Rican, etc.)	14.	Race - Ame	rican Indian,
ဖွ	after or its		1 ☐ Never Married 2X I	Married	Amed Fo	2 No		1 ☐ Yes		in, mexical Specify:		Hican, etc.)		Black, White	
93	72 hours "natural", polical Exe	d by	3 Widowed 4 Divor			des: 142-								ecify: wh	
215-0036	c * M	Completed	(Specify only hi	<u> </u>	cation completed)		16a. De (Gi	edent's Usu e kind of wo . DO NOT u	al Occupa rk done d se retired	ation <i>during mo</i> s ()	t of work	ring	16b. Kind o	f Business/	Industry
2	filed within Hygiene. Ither then "	E O	Elementary/Secondary (0-1	2)	College (1	I-4or 5+)		fesso		,			civi1	engi	neer
Q E	be filed within tal Hygiene. Ind other then event, the Meren	BeC	17. Father's Name (First, Mid	dle, Last)					-	18. Moth	er's Nam	e (First, Middle,			
Z FE	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the Market	ToE	Renwick G. I	ean						Mab	el K	ing			
and a	s 1 end 2 should f Health and Mer item 27 ie marke other traumatic		19a. Informant's Name/Relati		•		19b. Ma	iling Address	(Street 2	and Numb	er or Run	al Route Numbe	or, City or To	wn, State, Z	(ip Code)
2	ss 1 end 2 of Health item 27 i		Patricia Dear	spou	ise	anh	1008 D. Place of Dis			Road		Air, M			Y C4-1-
17 27 OC			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati		emoval from			ematory or		e)	'	Date	20c. Location	on - City or	Town, State
に記	permit. Page Department of Important: If any injury or once.		4 ∑Donation 5 ☐ Othe		10 0 4			22 Name ar	nd Addres	s of Facili	tv				
100	Dep Imp		2 Sunature of Funeral Suna	Sol	ad	irecto	or S	tate altim	Anato	omy B MD	óard 2120	655 W.	Balti	more	Street
			23a. Part 1. Enter the disease shock, or heart failure.	, or compli	cations that c	aused the de							rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1	dder	- Car	icer	•						Onset and Death
4	/Medical Examiner		resulting in death)			or as a cons		1	CC	, 7					17
- 1		_	Sequentially list conditions,	ь	Unro	or as a cons	renal	ins	utt	icie	MC	7			year
	ted nslt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	50000	or as a cons	equence oi):					1			1
Ć	execunand and ial-tra	Examiner	that initiated events resulting in death) Last	C	Due to (or as a cons	equence of):								
)9/	tate be executed thysicien and the burial-transit														
Capysion of Vitam Records, P.O. Box 68760,	certificate be executed Iding physicien and Ise as the burial-transl	Physician/Medical	IF FEMALE:												
S S S	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	2		irth 2 ☐ Fe	etal death	□Ectopic p					23d.	Date of deli Month	very Day Year
70	he de r the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregn 9□ Unkno	ant at time o	f death :	Other (sp	ecify)						Duy You.
D.	res thet the de igned by the be detached	y Ph	Partil, Other significant con-	ditions con	tributing to de	ath but not r	esulting in the	underlying o	ause give	en in Part I		23e. Did to	bacco use c	ontribute to	the cause of death?
	quires n sigr uld be	Completed by	Pulmonary	til	rosis	0						1 🗆 Y	es 2 N	3 □ Pro	obably 4 Unknown
	aw requir as been si 2 should l	piete	Congestive	2 he	art	fail	ure					24a. Was	an 24	b. Were au	topsy findings available completion of cause of
S.	i cian : The lav certificate has rector, page 2	E O	Company	av-	Foru	dic	ease					autop perfor	med?	prior to death?	
<u>्रव</u> ्ह	ysician: is certifice director, p	BeC	25. Was case referred to examiner?	lical	7		-450			26. Place	of Deat	h (Check only or	-	- 10103	2010
===	× 5 5	၉	1 Yes 2 No	Н			☐ ER/Outpat			4 NI	ırsing Ha	me 5 Resid	lence 6 🗆	Other (Spec	cify)
Ş	ding Phys	on	27. Manner of Death Natural 5 □ Per		28a. Date of	of Injury h, Day Year)	28b. Time Injun		28c. Injury Work			28d. Describe h	ow injury oc	curred	17
13:0		licat	3 Suicide 6 □ Co	estigation uld not be	28e Place	of Injury - At	home, farm,	M factor		Yes 2		28f Location /9	Street and No	mber or Ru	ral Route Number,
<u> </u>	after after Dire	Certification:	4 Homicide	ermined	buildi	ng, etc. (Spe	cify)	street, ractor	, omco			City or Tow		imper or ria	nar riodie rumber,
Z	To the Hospital or Attenwithin 24 hours after dealt To the Funeral Directors completely filled in by the		29a. Certifier 1 Certi	fying Phys	ician: 10 the	best of my k	nowledge, de	ath occurred	at the tim	e, date ar	d place,	and due to the d	ause(s) and	manner as	stated.
2	the Ho hin 24 the Fu	ledical	one		and men	asis of exami per stated.	nation and/or				ith occur	red at the time, o	date and plac	ce, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of der	itia	//1	-1			. License		_		A .	1	n, Day, Year)
				1	7 3				135	87	3		Apri	1 17,	2007 MD 21014
			30. Name and address of pers		mpleted caus	e of death (It	em 23a) (Typ		en ha	1 le 1	0-	Su'b 2	ne. R	11.	MADINIL
	Sta	te	31. Date filed (Month, Day, Yo	1	32. R	egistrar's Sig	nature P	rule	sape	ukel	Ji.	JUIT A	vo De	1/1/	11000019
*	Registr		APR 2	3 20	07	00,000	89 1	maste s	60						

State Registrar TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

2007

DIDOMEMICO

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

			_	pe or Print in Blac			-	-	
			For State	State of Maryland /	•		ental Hygien	е	
			Registrar		Certificate of		Reg. N	·2007	12888
	Physicia		1. Decedent's Name (First, Middle, Last)	L. DeA	N	1	2. Date of Death Month D	year Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	ma I a i	4b. City, Town, or	Location of Death	4	c. County of Death	10/
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
L	Director		178-44-7893 1⊠1 Usual Residence of Decedent	1 ²⁰ F 52	Yrs. Months Days	Hours Min.	Dec. 2, 19.	54 Reni	
	yland how at		10a. State 10b. County	10c. City, To	wn or Location	4		1	0d. Inside City Limits
	he Ma 28a-f s otified	Director	10e. Street and Number	†	10f. Zip Code	more	100.0	Citizen of What Coun	1 ☐Yes 2 ☐ No
	th with 23a or ist be r	al Dir	899 Ceci/	Ave	21	100	log. c	US	A
	r deat	Funeral	THE MAIN OF THE PARTY OF THE PA	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
ត់	72 hou natura dical E	Completed	15. Decedent's Educa (Specify only highest grade of		a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16b.	Kind of Business/Ind	dustry
7	filed within Hygiene. Ither than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired			Assis	ted
N	filed v Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)	NIA	Coun	18. Mother's Name ((First, Middle, Maide	en Surname)	ving
<u>a</u>	ld be ental ked o	To Be	Robert L	ee Dean		·		,	an Rasin
Mary	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street	1.6	1 - 1	or Town, State, Zip	Code)
≥ ຜົ	t and Health		Kenneth Jones 20a. Method of Disposition		of Disposition (Name of	re Hyatt		md. 20 Location - City or To	Win State
0	5 ± 5		1 ☐ Burial 2 ★Cremation 3 ☐ Rei	camai	tery, crematory or other place	(e) 4-25	-07	An a sit	la mob
altll	+ 투욕증		21. Signature of Funeral Service Licensee		22. Name and Addre		D Fred HIL	Ton Pac	2
<u> </u>	permi Depar Impor any Ir		JAN / 1/an	1	Gares P.		Funeral	Home Bae	to, md, 21229
			23a. Part 1. En or the disease, or complice shock, hear failure. List only one	ations that caused the death. Do	o not enter the m do of dyir	ig, such as cardiac or	respiratory arrest,	7	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death)	Due to (or as a consequence	cherotie	Ardiov	ASCLLAN	- DISEA	int
	Examiner			Diahetz	2.5				
/	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence	e of):				
_	xecute and al-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):			-	<u> </u>
200	te be e ysiciar ne buria	g	L _d .						
200	ntifica ng ph	Med	IF FEMALE:						
Š P	ath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	b. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)	/		23d. Date of delive Month	ery Day Year
j.	t the de by the ached	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	J Citier (specify)				
λ, T	es tha gned b	by P	Part II. Other significant conditions control		, ,			o use contribute to th	
0.00	requir	eted	Megantis C	, Seizur	re piso	rder	1 Tyes		
vital Records,	he law e has b ge 2 s	Completed					24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of
<u>ra</u>	an: T tificate or, pa		25. Was case referred to medical			26. Place of Death	(Check only one)	¶o 1 □Yes	2□ No
<u> </u>	ysicla iis cer direct	To Be	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 KR/C	Outpatient 3 DOA Oth	or.		6 □Other (Specif	·y)
0 0	ing Ph After th uneral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of lnjury 28c. Injur		8d. Describe how inj	ury occurred	
VISION	ttendi death. ctor: / the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home,		Yes 2 □No	Rf Location (Street:	and Number or Rura	N Route Number
2	al or A s after al Direct	Certification:	4 Homicide determined	building, etc. (Specify)	,,,,		City or Town, Sta		710010710111001
	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (cian: To the best of my knowled er: On the basis of examination a and manner stated.					
	To the within To the сотры	Med	29b. Signature and title of certifier	2 Depo	Afry 29c. Licens	e number	29d. D	Date signed (Month,	Day, Year)
			Millen	Ja, m	O U	0605	7	4/18/7	
	7		30. Name and address of person who com	Jones of death (Item 23a	mD 6	35 A	neric	A 21	255
I	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1				
	Registr	ar	APR 2 3 200	7 Jane J.	Anna .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) April 17, Day 2007 Year **Physician** 11:40 AM Carolyn Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Pineview Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 ▼ F 91 Director 472 10 8931 Crosby, MN July 26, 1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's Bowie 1 □Yes 2 TNo Directo 10e. Street and Number Summerville Woodward Estate 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14997 Health Care Drive 20716 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White 2 ₩Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Cafeteria Worker P.G. County School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hans Anderson Anna R. Goldberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 Eilerson Street, Clinton, MD 20735 Don Edwards (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 18, 2007 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Septice Livensee ran Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate To the Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 XIX Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 51520 April 18, 2007

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Southern

Ave SE #310, Washington, DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 18 Day 2007 Year **Physician** Carol Edwards B:15 p м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Cherrywood Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 173-38-2189 **Director** 60 June 21, 1946 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1028 Winsford Rd. 21204 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Examiner must) any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be Stanley Joseph Velehoski, Sr. Anne Rita Potaski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Tichy-daughter <u>6437 Lauren La., Spring Grove, PA</u> 17362 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Serv Corp 4 □ Donation 5 □ Other (Specify) 4/20/07 Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tra Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perfor certificate 25. Was case referred to medical examiner? director, Medical Certification: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

Director: / within 24 hours aft

To the Funeral D

completely filled in

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number D2511 29d. Date signed (Month, Day, Year) 19/200

MO2111/

Suite 101

30. Name and address of person/who completed cause of death (Item 23a) (Type, Print) ahoora

20, crossroads 32. Registfar's Signature

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			State of Marylan		artment of H			711117	12891			
Ŷ.			Registrar 1. Decedent's Name (First, Middle, Last)		incate or i		2. Date of Dea	Reg. No.	3. Time of Death			
	Physici /Medic		Kenneth John Erickson				April	19, 2007 Year	9:25 p M			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D		4c. County of Death	7 3 2 2 2			
	() ()		6330 Northbrook Dr.		Dunkirk	1 1611-1-041		Anne Arur				
1.7	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Min. (Month, Day	y, rear) Cou.	**			
EX.	The garages was 1		559-16-5987 82 Usual Residence of Decedent				July 1,	1924 Wash	nington			
	arylan show d at	-	10a. State 10b. County 10c. City	, Town or Loc	cation				10d. Inside City Limits			
	he Ma 28a-f 9 otifie	Director		h Hig	hlands				1 □ Yes 2 □ No			
	with t laor? then	i Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of What Cou	ntry?			
	ns 23	Funeral	5038 Valley Forge Lane 12. Was Decedent Ever in U.	3. 13. V	95660 Vas Decedent of H	Ispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)	USA 14. Race - Americ	can Indian,			
ဖ	after o		1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Married 1 Never Married 1 Never Married 2 Narried 2 Narried 1 Never Married 2 Narried 1 Never Married 2 Narried 2 Narried 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 1 Narried 2 Narried 1 N			an, Mexican, Po Specify:	uèrto Rican, etc.)		etc.			
003	ural",	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		Yes 2√√2 No				nite			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give I life. L	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of f)	working	16b. Kind of Business/In	dustry			
212	yiene. r thar the N	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Sale		,		Zenith Distributir	na Corp.			
	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's I	Name (First, Middle,		g corp.			
yla	2 should be to and Mental I s marked or raumatic eve	2	Nels Albin Erickson			Christ	ine MacDo	onald				
Maryland	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State, Zij	Code)			
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Kenneth Riley-nephew 20a. Method of Disposition 20b. P		Northbroc sition (Name of natory or other place		Dunkirk,	MD 20754 20c. Location - City or To	own, State			
ē	9 0 L F		Toleriation 3 Memoval nom state		natory or other place matory		20/2007	Catonsville,				
altimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee					ome at MMP,				
<u> </u>	8 3 E 8 8		M Pgh	7:	<u>250 Washi</u>	ington	Blvd., Ell	kridge, MD 2				
52k, 10	* 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	Physician /Medical		resulting in death)	a. Lung cancer								
	Examiner		Due to (or as a d) nsequ									
41	T. F	Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury) Due to (or as a consequence of the consequence)	ence of):								
	cuted nd ransit	Examiner	that initiated events c									
30,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequ	ence of):			_					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical	d									
Box 6	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregna	псу				23d. Date of deliv	env			
	death e atte	icia	in the past 12 months? 1☐Live birth 2☐ Fetal		Ectopic pregnancy Other (specify)			Month	Day Year			
<u>Р</u>	at the de by the a stached	hys	9 ☐ Unknown									
	res tha signed b	by	Part II. Other significant conditions contributing to death but not resu	iting in the un	derlying cause give	en in Part I.		obacco use contribute to t	. .			
Š	w require been sig should b	eted					- W	′es 2 No 3 Prol	Dably 4 Diphknown			
Vital Records,	he law e has ige 2 s	Completed					– 24a. Was a autop	an 24b. Were auto sy prior to co rmed? death?	ppsy findings available mpletion of cause of			
<u>a</u>			25. Was case referred to medical			26 Place of I	1 Yes Death (Check only or	2 No 1 □Yes	25,00			
	Physici this cer al direct	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA Othe			lence 6 ther (Special	Nephew's			
n or	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at	28d. Describe h	low injury occurred	~ Restuence			
200	or Attenditer death.	cati	2 Accident investigation 3 Suicide 6 Could not be	mo form atra		Yes 2 □ No	000 1 10 (0		-			
Division	lor A after Direct	Certification:	4 Homicide determined 28e. Place of injury - At no building, etc. (Specify)	et, ractory, office		City or Tow	Street and Number or Rura n, State)	al Houte Number,			
	pspita hours ineral y filled		29a. Certifier Certifying Physician: To the best of my know	vledge, death	occurred at the tin	ne, date and pl	lace, and due to the	cause(s) and manner as s	itated.			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	on and/or inv			occurred at the time,	date and place, and due t	o the cause(s)			
	o T with	2	29b. Signature and title of certifier		29c. License	number	*	29d. Date signed (Month,	Day, Year)			
,	1	-	20 Name and discount who constituted the first	220) /T	1700	10054	72	TIXOLOT				
1	C		30 Space and address of person who completed cause of death (Item	LJan (Type, F	21100	140	214	01				
	Sta	te	31. Date filed (Month, Day, Ver) 32. Registrar's Signat		<i>y</i> 0				<u> </u>			
	Registr	ar	APR 2 3 2007 Januar 15	Road								

			For 1 _ State	ļ	State	of Mary	land / De	partm	ent of H	lealth a	and Me	ental Hyg	giene	2007	1289	2
			Registrar	dialette Land			C	ertitic	ate of I	Death		2. Date of Dea	leg. No.		I o Time of Dooth	
	Physici	an	1. Decedent's Name (First, M							Day	Year	3. Time of Death	Λ			
	/Medic		ANNA		M.	imbor!	EN	GELSE		r Looption		APRIL	19,	2007 County of Deat		_
	Examin	er	4a. Facility Name (If not insti GENESIS PERR.					40. C	ity, Town, o	KVILL				BALTIMO		
100	Euporal	-	5. Social Security Number	6. Sex	TAWAL		yrs. last birtho	ay) If Ur	der 1 Year	If Under		8. Date of Birth	1		hplace (State or Foreig	ın
ш	Funeral Director		213-62-0262	1 🗆 !	м 2 ДГ F	54		Mont	hs Days	Hours	Min.	(Month, Day 10/21/	r, Year) 1952	Co	uintry) RYLAND	
1100	70		Usual Residence of Deceder	nt								10/21/	17,7~	141	(IBIND	
	ırylan show	_	10a. State 10b. Co	unty		10	c. City, Town o	r Location							10d. Inside City Limits	
	e Ma Ba-f s	cto	MD BALTIMORE PARKV												1 ☐ Yes 2 ☐ X No)
	or 2	Director	10e. Street and Number					10f.	Zip Code			1	I0g. Citize	en of What Co	ountry?	
	s 23a	Funeral	8610 OAKLEI			1 1 1		10.111	212		10/0		4.	USA	dee lede	
	er de items	nue	11. Marital Status		Armed F		in U.S.	If Yes,	ecedent of H specify Cuba	ispanic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- lican, etc.)	12	 Race - Ame Black, White 		
36	rs aft	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		If Yes, G Year or I	2 MNo ive Dates:		1 ☐ Ye	s 2□ X o	Specify:			5	Specify:	VHITE	
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at			edent's Educa			16a. De	ecedent's l	Jsual Occup	ation			16b. Kind	d of Business/	Industry	_
15	nin 72 r "ne Medic	plet	(Specify only h	ighest grade (completed)) (1-4or 5+)	(G	(Give kind of work done during most of working life. DO NOT use retired)							,	
212	d with giene er tha the I	Completed	8TH GRADE	12)	College	(1-401 5+)	FA	CTORY	WORK	ER		PLAST			rc .	
pu	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)									(First, Middle,	Maiden S	urname)		
Maryland 21215-0036	2 should be f n and Mental is marked of raumatic eve	To	KENNETH G	OLDSTR	AW					TH	IELMA		DUF	RKIN		
lar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Rela				19b. M	ailing Addı	ess (Street	and Numbe		Route Numbe			Zip Code)	
	1 and 2 Health em 27 i		EDWARD C. ENG	ELSKIR	CH/HU				AKLEIG		D BA	LTIMOR		D 2123 ation - City or		
Baltimore,	ages If ite or o		1 ☐ Burial 2 X Cremat		moval from	State	Ob. Place of D cemetery,	crematory	or other plac	e)	Da		200, L00	ation - City or	Town, State	
Ħ	iit. Partmel		4 □ Donation 5 □ Oth 21. Signature of Fune al Ser				METRO C	REMAT	YORY,	INC.	_4/20	2007	CAT	ONSVILL	E. MD HOME, P.A.	1111
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.			VIGO EIGOTIGO		/			LOCH				WSON,		11286	
,	* *		23a. Part Enter the diseas	e, or complica	ations that	caused the	death. Do not								Approximate	
	Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Apprinter onse limmediate Cause (Final disease or condition										Interval Between Onset and Death			
	/Medical		resulting in death) Due to (or as a consequence of):										you,	_		
	Examiner		Sequentially list conditions, b.													
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	~	Due to (or as a consequence of):											
	xecut and II-tran	хап	c												_	
8760,	icate be executed physician and s the burial-transit	dical E	d													
687	ificate g phy: as the	edic		a.				-				_				
Вох	death certific e attending p d for use as i	N/	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□Ectopic pregnancy									23	d. Date of del	· ·		
	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time		5 ☐ Other					Month Day			
P.0	w requires that the d been signed by the should be detached	hy	9 🗆 Unknown									177	- 1			
Š,	res th igned be de	by	Part II. Other significant con	nditions contr	ibuting to c	death but no	ot resulting in th	e underlyir	ig cause give	en in Part I.	•			_	the cause of death?	
orc	requi	ted	Masheria									1 L Y	es 2	-No 3∐Pr	obably 4 □Unknowi	,
Division or Vital Records,	2 3 a	Completed by	recoverA 1/e	د ت								24a. Was a autops	sy	prior to o	itopsy findings available completion of cause of	Э
a F	the The cate ; pag											perfor 1∐ Yes	med? 2 No	death? 1 ☐ Yes	2 No	
Zit.	ician certifi rector	Be	25. Was case referred to me examiner?	-	spital:				DOA Othe			(Check only or				_
ō	Phys r this ral dii	-L	1 Yes 2 No		28a. Date	· ·	2 ER/Outpa		DOA	4 🖂 INU		e 5 Reside			cify)	_
on	Attending Physician: If death. ector: After this certific by the funeral director,	tion	1 ■ Natural 5 □ Pe	ending restigation		nth, Day Ye			28c. Injun Worl	k?ີ Yes 2 □		od. Describe in	ow mjury	occurred		
/isi	Atter r deal ector	lica	3 ☐ Suicide 6 ☐ Co	ould not be	28e. Plac	e of injury -	At home, farm	street, fac	tory, office		28			Number or Ru	ıral Route Number,	
ā	s after salter all Dir	Certification:	4 🗆 Homicide		Dulic	ling, etc. (S	респу)					City or Tow	n, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page		(Check only 2 Med	ifying Physic	ian: To the	e best of m	y knowledge, d mination and/d	eath occur	red at the tin	ne, date ar	nd place, ar	nd due to the o	ause(s) a	ind manner as	stated. to the cause(s)	
	the I	Medical	one)		and mar	nner stated.			20c License	number.			Od Date	nianed (Mont	h Day Yourl	
	S M K		29b. Signature and title of ce	3/11					D 7	/ > 0 —	_	2	.gu. Date	signed (Monta	ii, Day, 16arj	
	\cap		Wind	Lung	mla41-		/ltam 00 \ /=	D 2 1	1/5	171			7/	117111		
1	4		30. Name and address of pe		pieted cau	Se of death	N CL	cus	St.	Sute	7202	70w	ism	2md	2/20 Y	
	Sta	te	31. Date filed (Month, Day,	/ear)	32	egistrar's	Signature	hard								_
	Registr	ar	APR	2 3 200	7 1	BURN	D. 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician April 19^{pay} 2007^{ear} 7.20PM_M Munford Fortune Lloyd /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Temple Hills 6307 Summerhill Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 24,1927 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 □ F Virginia 228-42-6437 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 □tNo Director Temple Hills Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20748 6307 Summerhill Road permit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23; any injury or other traumatic event, the Medical Examiner must Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 KMarried African Baltimore, Maryland 21215-0036 1 ☐ Yes 2**Æ**No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Post Offic Postal Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Courtney Ethel Will Fortune ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6307 Summerhill Road Temple Hills, Maryland 20748 19a. Informant's Name/Relationship (Type. Print) Judy Fortune (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APrilate 28, 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2√∏ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5XXResidence 6 Other (Specify) Hospital: 1 Yes 2 No ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? I Director: After to in by the funera Certification: 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Mixertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 20, 2007 D23743

State Registrar

31. Date filed (Month, Day, Year)
APR 2 3 2007

Martin Weltz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 1- Statemend #10e &19b Per FH G866 4/20 entities of Death 3001 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Mangay6t Francis 8 hrs 20ml 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COMO Baltimure Washing ton If Under 1 Year If Under 24 Hrs. Ann6 MEdical 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔽 F 212-24-8052 Director 4/25/1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Anne Arundel Directo Severn 1 □Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7853 Linden Ave. 7853 Linden Leaf RD. 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ E No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett Lee King Dorothy Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1. Linden Leaf Rd 1853 Linden Ave. Severn, MD 21144 Noel Francis Husband Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2007 Elkridge, MD Meadowridge Memorial Park 4 Donation 5 Other (Specify) 21. Si ture of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 M01378 Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Immediate Cause (Final disease or condition resulting in death) **Physician** Kig /Medical Due to (or as a consequence of): Examiner bertensten Sequentiary liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a non equence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed muscular sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ို Jay 46596 aspres 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYASHREE AMBLE Baltimore Washingle- Medical 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State APR 23 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 1 6 **Physician** Month 04 1:45 PM Eleanor Gentry 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL GOOD If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 20, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 💢 F 1014 Maryland 578-36-6217 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 TYYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1643 Penwood Road 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ≥ Specify: black 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housekeeper private homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Brown 2 Doshia Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Wellborn/sister in law 501 E. Preston Street #116 Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Qther (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street man -Baltimore, MD 21201 2 a. P. rt1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner ENCEPHALOPATHY Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. the 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE LOCH RAVEN BOULEVARD KARHADKAR 5601 ARATI 31. Date filed (Month, Day, Year) Registrar's Signature State APR 23 2007 Registrar

DHMH 17 Rev 1/2001

LEANORA

ENTR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year JOHN CARLTON GARTNER, SR. April 20, 2007 4:30P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F 579-10-1680 12/27/1915 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No GLEN ARM BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11300 OLD CARRIAGE ROAD 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 4+ YEARS FBI AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES A. GARTNER BEULAH BATN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 FIELD RD. DR. J. CARLTON GARTNER, JR./SON WILMINGTON, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/24/2007 MT. MARIA CEMETERY 4 □ Donation 5 □ Other (Specify) TOWSON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Int. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause of a ch line. Approximate Interval Between Onset and Death hock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) renal Due to (or as a consequence of): Hypovolemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes OVOD Col 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy per ensia case referred to medical

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

show

-28a-f

23a or

2

"natural",

other than

27 Is I

permit. Pages 1 am Department of Healt Important: If item 2 any injury or other once.

Medical

filed within 72 hours after

pe marked

Baltimore, Maryland 21215-0036

must be notified at

Director

Funeral

þ

Completed

Be

ပ

physician and s the burial-trans s been signed by t should be detach

The law requires that the death certificate be executed

Physician:

or Attending

To the I

after death.

I Director: /

within 24 hours a

To the Funeral I

completely filled Hospital

Medical

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical To Be Completed by Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

aminer?

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

☐ Yes,

21 No

Pag II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury

26. Place of Death (Check only one)

1 Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	OA	Other:	4 ☐ Nursing H	lome	5 ☐ Residenc	e 6 □Other
Date of Injury (Month, Day Yea	ar)	28b. Time of Injury		28c.	Injury a Work?	t	28d.	Describe how i	njury occurred

5 Pending investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

M 1 ☐ Yes 2 ☐ No

1 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier NW)

29c. License number

(Specify)

30. Name and address of person who completed cause eath (Item 23a) (Type, Print)

6701 MP 31. Date filed (Month, Day, Year) 32 Registrar's Signardie

Hospital:

Charles St.

State Registrar

					State of	i Maryla		-	ment of I <i>ficate of</i>	Health and Death	Mental Hy	/gieŋ Reg. N	200	-7	12897
ı	Physic		Decedent's Nam	e (First, Middle	e, Last) Abraha	m Gra	ber				2. Date of Do Month April	eath Da		Year 07	3. Time of Death 12:25 PM
April 194	/Medi Examii Funeral		Collin	gswood	n, give street and num Nursing C 6. Sex 1 △ M 2 □ F	enter 7. Age (In yn		M	Under 1 Year	4b. City, Town, or Rockv If Under 24 Hrs Hours Min.	ille 8. Date of Bi	th 4	c. County o	of Death	1
	Director		075-14-4: Usual Residence o	Decedent	10 (6) 201	103		rs.			February	722,	1904	Kuss	12
	Manyla f shov	ō	10a. State Maryland	Montg	Om 0 737	10c. C		or Location						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Nu		Oldery		OC. J.	7	Of. Zip Code			10g. C	itizen of W	hat Coun	try?
	th with	ai D	16900 W	estbour	ne Terrac	е			208	378	er e	Un	ited	Stat	:es
020	urs efter des al', or items Examiner m	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	_	12. Was Dece Armed For ied 1 ☐ Yes If Yes, Give Year or Da	ces? 2 🖸 No	U,S.	-	Decedent of I s, specify Cub Yes 210 No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	0-		c, White, e	an Indian, etc. iite
Maryland 21215-0020	1 end 2 should be filed within 72 hours efter death with the Maryland Health end Mental Hygiene. em 27 is marked other then "netural", or items 23a or 28a-f show wither traumatic event, the Medical Examinar must be notified at	Completed	(Spec	t's Education at grade completed) College (1-	4or 5+)	16 <i>a</i> .	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Artist			16b. Kind of Business/Industry			lustry		
ğ	other vent,	Be	17. Father's Name	(First, Middle, I	Last)				10.11	18. Mother's Na	me (First, Middle	, Maide	n Sumame		
ylaı	ould b Menta arked	To E		l Grabe						Kathe	rine Ab	ramo	ff		
Mar	d 2 sh th end 7 Ism traum		19a. Informant's Na George (and Number or Runne Terra					
ē,	s 1 enc f Healt Item 27 other 1		20a. Method of Disp	osition		20b.			n (Name of ry or other pla	,	Date		ocation - C	<u> </u>	
<u>m</u>	Page:		1 □ Burial 24 4 □ Donation		3 □Removal from S pecify)	tate			ny or omer pra matorium	- 12	April 19,2007	Bet	hesda	a, Ma	aryland
Baltimore,	permit. Pages 1 en Depertment of Heal Important: If Item 2 any Injury or other once.		21. Signature of Fu	neral Service I	Licensee ANALLY	M013	05	Robe	me and Addre	ess of Facility Pumphrey	Funeral	. Hor	me/Ro	ckvi 11e.	11e, Inc. MD 20850-280
1	Physician		23a. Part1. Enter the shock, or hear	ne disease, or it failure. List	complications that ca only one cause on ea	used the dea	ath. Do no	J							Approximate Interval Between Onset and Death
j	/Medical Examiner		Immediate Cause (disease or condition	Final n	P	nec	m	on	12					1	days
		er	resulting in death)			Due to	(or <i>a</i> s a co	onsequen	ce of):						
(09	ificate be executed g physician end es the burial-trensit	ai Examiner	Sequentially list conif any, leading to imcause. Enter Under Cause (Disease or	nditions, mediate rlying injury	b	Due to ((or as a co	onsequen	se'at).						
Box 68760,		an/Medicai	that initiated events resulting in death) L	\	d	Due to (oras a co	nsequenc	ce of):						
	thet the death cert ed by the ettendin detached for use	Physician/N	Part II. Other signifi	cant condition	ns contributing to dea	th but not re	sulting in	the underl	ying cause giv	en in Part I.	23b. Did	tobacco	uae cont	ribute to	the cause of death?
s, P.O.	ss thet th gned by be detacl	by Ph			-						10	Yes 2	2□ No	3 🗆 Prob	ably 4 dunknown
Division of Vital Records,	e law requires thet has been signed b ge 2 should be dete	Completed									24a. Was perfo	an auto rmed?	opsy	ava	re autopsy findings ilable prior to npletion of cause leath?
a H	t ag										10	Yes 2	□No	1 🗆	lYes 2□ No
Ζ	Physicien: this certific ral director,	To Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☑		Hospital:	patient 2	TER/Out	ationt 3	□ DOA Oth	26. Place of Dea	ith <i>(Check only o</i> Iome 5□ Resi		6 MO#**	(Cit	
ion of	To the Hospital or Attending Physicien: within 24 hours ster death. To the Funerel Director: After this certifical completely filled in by the funeral director,		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending	28a. Date of (Month		28b. Ti	me of ury	28c. Injur Wor		28d. Describe				<u>'</u>
Divis	tal or Atters of the set of the s	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ned 289. Place of building	g, etc. (Speci	ify)		actory, office		City or To	wn, State	θ)		Route Number,
	the Hospital hin 24 hours the Funerel npletely filled	edical	one)	2 ☐ Medical E	Physician: To the becaminer: On the bas and manner	as of examina	owledge, ation and/	death occ or investig	gation, in my o	pinion, death occu	, and due to the rred at the time,	date an	d place, ar	nd due to	the cause(s)
	co o with		29b. Signature and	Th	() sh	in				20148	3	29d. Da	Pri	(Month, D	2007
	5		Ote	ien li	no completed cause	(111	Xpe, Print	ch A	ve. (Saither	sbi	urg	Mg	
	Sta Registr	rc	31. Date filed (Mont	PR23	2007	giŝtrar's Sign	A L	6034	(1)						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Пау Month BERNARD HERMAN APRIL18, GORDON 2007 5:25P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPICE OF BALTIMORE GILCHRIST CTR TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Months Days Hours Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 116-07-3076 88 10/08/1918 NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT, APT. 546 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN GORDON FANNIE KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN FRIED / DAUGHTER 203 DELIGHT MEADOWS ROAD, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cametery, crematory or other place) MIKRO KODESH BETH ISRAEL CONGREGATION 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/20/2007 | BALTIMORE, 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complicators hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence all Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1□ Yes 2 No 1 ☐ Yes 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner

certificate be executed

P.O. Box 68760,

or Vital Records,

Division

Physician:

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23sury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

ဂ္

with the Maryland

burial-transit as the use detached for

Examine and attending physician Physician/Medical the \$ Completed has certificate Be 2 this To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 ☐ Homicide

1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

6701

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2007

11 Ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11) A R-12-1 (BMC 6701 A. Choles St. Balto. Md Zc 20) BMC

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature APR 2

Registrar DHMH 17 Rev 1/2001

State

completely filled in by the

Medical

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** HAROLD KOSIE 5:30 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Charles Village Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🌠 F 216-28-9476 Director 76 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 2327 N. Charles Street 21218 USA "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any rigury or other traumatic event, Ire Magnes. Elementary/Secondary (0-12) College (1-4or 5+) housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Sydnor/son 1641 Walworth Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 Nother (Specify) in state 21. Sign and of Funeral Service Ronald 22. Name and Address of Facility Board 655 W. Baltimore Street m Baltimore, MĎ 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ca Physician Har. /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and al-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burialby Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Division of Vital 25. Was case referred to medical 26. Place of Death Check onl one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Than foon, N) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 ST. Paul Plan #701 Bottom , www 21202 2. Registrar's Signature 31. Date filed (M State Registrar

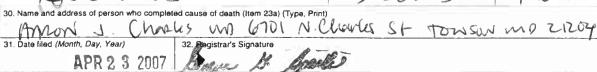
	1 - State Registrer			-	artment of F			2001	16301
		ne (First, Middle, La	ist)		rimouto or i	Dodin	2. Date of Death	g. No.	3. Time of Death
ician	Maravene	e D. Hamb	urger				Apr	5 ^{ay} 2007	7:35 рм
lical iner	4a. Facility Name ('If not institution, gi	re street and number)		4b. City, Town, o	Location of Death		4c. County of Dea	ith
	503 Bri	ghtfield	Club Drive	2	Luther	ville		Baltimo	re
	5. Social Security N		Sex 7. Ag 1 □ M 2 反 F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	213-38-65 Usual Residence of	51/	- X	92 Yrs.			Nov 23,	1914 Pen	nsylvania
	10a. State	10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
ρ	MD	Baltimo	re	Lutherv	7i11a				1 ☐ Yes 2 ☐ No
Director	10e. Street and Nu	7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	10f. Zip Code		10	g. Citizen of What C	ountry?
a	503 Bri	ghtfield	Club Drive	2		21093		USA	
Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
by Fu		ried 2 Married	1 ☐ Yes 2 🕅 If Yes, Give	No	1☐Yes 2X No	Specify:		Specify: Wh	
D D	3 X Widowed	15. Decedent's E	Year or Dates:	163 Dece	dent's Usual Occup	ntion	1	6b. Kind of Business	Maduata
Completed		cify only highest gr	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ring '	ob. Kind of business	undustry
E	Elementary/Second 12	ondary (0-12)	College (1-4or		egistered	nurse		healthcar	:e
Bec	17. Father's Name	(First, Middle, Las.)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
70	Canby D	eveney				Hila	ria Lipp	У	
		lame/Relationship						City or Town, State,	
		ldthorpe/	daughter					herville,	
	20a. Method of Dis 1 ☐ Burial 2	•	☐Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac		Date 2	Oc. Location - City or	Town, State
		5 Other (Speci							
	21. Signature of R	onald S					655 W. I	Baltimore	Street
	23a Part1 Enter t	the disease or con	polications that caused	the death. Do not en	altimore, ter the mode of dvin		or respiratory arre-	st	Approximate
	shock, or hea	art failure. List only	one cause on each li	ne.		g, 30011 03 001 0100	or respiratory arre-	Ji,	Interval Between Onset and Death
	disease or condition resulting in death)	on		a consequence of):	Inuve				years
			Due to (01 as	a consequence or,					
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):								
Examiner	Cause (Disease or that initiated events	ri <i>n</i> ijury s	C						
_	resulting in death)	Last Due to (or as a consequence of):							
lica		•	d						
Med	IF FEMALE:								
lan/	23b. Was deceden in the past 12			2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
ysic	1 ☐ Yes 2 9 ☐ Unknown	No	4∐Pregna <i>n</i> t a 9∐Unknown	t time of death 5L	Other (specify)				,
Completed by Physician/Medical	Part II. Other signif	ficant conditions	contributing to death b	out not resulting in the u	Inderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
d b	heart d	iscase,	dementia				1 ☐ Yes	s 20 X0 io 3⊟P	robably 4 Unknown
lete							24a. Was an	24h Wara a	utopsy findings available
d L							autopsy	ed? prior to death?	completion of cause of
e e	25. Was case refer	rred to medical				26 Place of Deat	1 ☐ Yes 2		s 2 No
TOB	examiner? 1 ☐ Yes 2 💆		Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3 DOA Oth	or		nce 6 □Other (Spe	acifu)
	27. Manner of Deat	th	28a. Date of Inju (Month, Da	ry 28b. Time o		make the same to be a same to the	28d. Describe how		scily)
atio	1 Natural 2 ☐ Accident	5 Pending investigation		y Year) Injury		Yes 2 □No			
Certification;	3 Suicide 4 Homicide	6 Could not be determined	286. Place of in	ury - At home, farm, st	reet, factory, office		28f. Location (Stre	eet and Number or R State)	ural Route Number,
	29a. Certifier	1 Certifying Pi	nysicien: To the best	of my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the cau	use(s) and manner a	s stated.
cai	(Check only	2 Medical Exe	miner: On the basis o	f examination and/or in	ivestigation, in my of	omion, death occur	ieu at the time, dai	te and place, and du	e to the cause(s)
Medicai	one)	2 ☐ Medical Exe	and manner st	f examination and/or in ated.					
Medical		2 ☐ Medical Exe	and manner st	f examination and/or in ated.	29c. License		29	d. Date signed (Mon.	th, Day, Year)

State Registrar

APR 2 3 2007

AMON J.
31. Date filed (Month, Day, Year)





Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2007 1:15P M Vilma Hopkins 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Elkridge 5950 OLD Washington Road If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) Dec. 31,1928 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Months 1 □ M 2 1 F Dec. 78 106-22-8343 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 X No Elkridge Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5950 Old Washington Road 21075 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Howard County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Vice Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Roscoe Andrew Roscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Hopkins (Son) Box 125 Winthrop, Washington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 XCremation 3 ☐ Removal from State 4-25-2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): f pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy Fetal death Month Day ime of death 5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

'natural', or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

other traumatic event,

ō

Injury

any Ir

Director

Funeral

<u>ک</u>

Completed

Be

၉

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other than '

physician and s the burial-trans ası attending p use ed by the a page 2 s funeral director, this

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

after

within 24 hours a

Examiner

Completed by Physician/Medical

Be

ဥ

Certification:

Medical

State

Registrar

IF

23

FEMALE: b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 Live birth 2 4 Pregnant at ti 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ato SO of Predation-

23e. Did tobacco	use con	indute to the ca	use of death?
Ves :	2□ No	3 ☐ Probably	4 □Unknown
24a. Was an autopsy performed?		prior to complet death?	
1□Yes 2□N	0	1 Yes 2	No

a un for		
25. Was case referred to medical		26. Place of D
examiner?	11 21 4	Cult

	1□ Yes	2□No	1 🗆 Yes
n (C	heck only	ne)	
me	5 Resid	ence 6	□Other (Specity

1 ☐ Yes 2 ☐ N	0
27. Manner of Death	
1 Natural	5 Pending
2 ☐ Accident	investiga
3 ☐ Suicide	6 Could no

ig	28a. Date of Injury	28b. Time of
gation	(Month, Day Year)	Injury
not be	28e Place of injury - At he	ome, farm, stre

Но	spital: 1 Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	OOA	Other:	I ☐ Nursing ⊢	lor
	28a. Date of Injury (Month, Day Ye	ar)	28b. Time of Injury	М		Injury at Work?	2 🗆 No	2

		· a c i i c	,, ,		
28d.	Describe	how	injury	occurred	

4 Homicide	е
9a. Certifier	Sertifyir
(Check only	2 ☐ Medical

ne, farm, street, factory, office building, etc. (Specify)

ng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

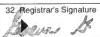
29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, APR 23 2007





07-03033 Darius M. Higgs Physician/ Medical Examiner **Funeral** Director any Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Month Day April 20, 2007 Darius M. Higgs 1700 hrs 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Min. Months Davs Hours 1XXM 2 CountryMaryland 215-32-7676 70 Feb. 6,1937 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show a Baltimore MD Reisterstown 1 Yes 2XXNo permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13208 Maple Grove Ave. 21136 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2XX Married XX No Yes White Yes XX No specify: Widowed Divorced f Yes, Give Yea Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ If item 27 is marked other than

If item 27 is marked other than Chief Engineer Boilers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin H. Higgs, Sr. Cora G. Reeder Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene E. Higgs/Wife 13208 Maple Grove Ave. Reisterstown, MD 21136 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, crematory or other place) Burial 2 XXCremation 3 Removal from State 4/23/07 portant: Metro Crematory Inc. Baltimore, MD Donation 87 Other Specify 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licer 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease a aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed ian/Medical X UNPENDED attending physician for use as the burial #2532,27,perME,G867, 5/15/07 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 Physici signed by the atter 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o è Yes 2 No 3 Probably 4 V Unknown مَ Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 V Yes No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death cation: 1 X Natural Division Yes 2 No Pending the 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Certific 3 Suicide Could not be or Town, State) determined (Specify) To the Funcral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Many) Ray.

gistrar's Signature

Year)

2007

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2007 **Physician** Month 19, April 4:11 PM James Krometis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1055 W. Joopa Road #649 Touson Baltimore 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 215-14-5585 84 Director Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1055 W. Joppa Road # 649 21204 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>ک</u> Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Principal Elementary/Secondary (0-12) College (1-4or 5+) Financial Group 12 General Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Evangelos Krometis Evangelia Contoviannis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela N. Krometis wife 1055 W. <u> Joppa Road # 649; Towson, MD 21204</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Other (Specify) 4 □ Donation 4/23/07 Greek Orthodox Cem. Baltimore, MD 21. Signature of Fundal Prvio Livense 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson. MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) EREBIZL scular Accident ACUTE /Medical Due to (or as a consequence of) ONSET Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MINUTES Due to (or as a consequence of): Examiner To the Hospital or Attenting Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 22100 1 🗌 Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perfo 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred after death. Certification: 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n: To the best comy knowledge, death occurred it the time, date and place, and due to the cause(s) and manner as stated.

On the best comy knowledge, death occurred it the time, date and place, and due to the cause(s) and manner as stated.

On the best comy knowledge, death occurred it the time, date and place, and due to the cause (s) and manner as stated. within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier Certifying Physic (Check only one) , in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MICIC MELL 120 30. Name and address of person who ted cause of death (Hem 23a) (Type, Print) 10+1

DHMH 17 Rev 1/2001

State

Registrar

Nick

31. Date filed (Month, Day, Year)

Mellis

ORIGINAL

32. Registrar's Signature

APR 2 3 2007

2352 York Road; Timonium, MD 21093

07-03020 Lawrence Frede	erick	Knperlein, Jr. Sta	e or Print in Bl te of Maryland	/ Departm	ent of	Health an	e All Co p d Mental	oies Are L Hygiene	-egibl	е.	·	200
		1- For State Registrar		Certific	ate of	Death			Reg. No	. 21		290
Physici Medical Exam	an/ iner	Lawrence	Frederick		rleir	ı, Jr.		2. Date of D Month April 20		Year	3. Time o	
*		4a. Facility Name (if not institution, University of Maryland N			4	b. City, Town, or Baltimpre	Location of De	ath	4	c. County of	Death	
Funeral Director				e (In yrs. last birt	hday)	If Under 1 Year		Hrs. 8. Date of	Birth(MM		Birthplace (Sta Foreign	ate or
		Usual Residence of Oecedent	M 2 F	57	Yrs.		1	02/	17/19	950	Country) Ma	ary1and
id how any <u>ce.</u>	_	10a. State 10b. County MD Cari	ro11	10c. City, Town			_					le City Limits
Marylar 28a-f s	Director	10e. Street and Number	1011		5	ykesvil 10f Zip Code	1e		10g. Cit	tizen of Wha		- Z X 110
death with the Maryland or items 23a or 28a-f show		7626 North S	School Hous		13 1/100	2 Decedent of His	1784	Cir-V		U.S.A		
215-0036 be filed within 72 hours after death with the Maryland mla Hygiene. They office than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Marri	ied Armed Forces?		If Ye	es, specify Cubar	n, Mexican, Pue	rto Rican, etc.)	No-	14. Race - White,	American Indian, etc.	Black,
ours afte atural",	þ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates: V only highest grade con		Decedent	Yes 2 X No	tion (Give kind		16b.	Specify: Kind of Busi	Whi ness/industry	lte
36 hin 72 h e. fthan "n dical E	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 8	0+)		st of working life		,				
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene n 27 smarked other than numadic event, the Medica		17. Father's Name (First, Middle, La	•		.comm	unicatio	on Supe 18. Mother's Na	TVISOT me (First, Middl	G10 e, Maiden	obal T Surname)	Cech_	
2121 buld be 1 Mental marketic event	To Be	Lawrence Freder 19a. Informant's Name/Relationship	ick Knoerlo		. Mailing	Address (Stree	Anna	M or Rural Route N	. So	chuler	State, Zip Code)	
, MD and 2 sh ealth and em 27 is		Margaret Knoerle	in Wife	≥ 76	26 N	orth Scl	nool Ho	use Roa	d Sy	ykesvi	11e, MD	21784
more		1 Burial 2 X Cremation		ite cremato	ory or othe	• •		Date			City or Town, State	3
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		<u> Carro.</u>	22. Na	remation ame and Address	of Facility	11824	Reist		wn Road	
Physician	-	23a. Part / Enter the disease, or con	mplications that caused	the death. Do not	ELI:	NE FUNES mode of dying,	RAL HOM	E Reis	terst	OWn,	MD 2113	36 nate Interval
/Medical caminer		failure. List only one cause on	each line. a. Multiple Injuries Due to (or as a conse								Between	n Onset and Death
	ě	Sequentially list conditions, if any, leading to immediate	b	quence of):								
=	Examiner	cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death). Last	Due to (or as a conse	quence of):								
executed in and I - transi	_ 1	UNPENDED	d.									
60, ate be	Medi	IF FEMALE:	AMENDED 23c. If yes, outcome	e of pregnancy					Loo	d. Date of de	Nine -	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at t	2		I death 3	Ectopic preg	nancy		Month	Day	Year
s, P.O. Book intest that the definition is signed by the definition of the definitio	ক্র	Part II. Other significant conditions		but not resulting	in the un	derlying cause gi	iven in Part I.				re to the cause o	
cords law requestable beer 2 should	Completed							24a. Wa aut per	as an copsy formed?	24b. We	ere autopsy findin or to completion o ath?	gs available
Vital Rec ysician: The his certificate		25. Was case referred to medical	1			26.Place	of Death (Chec		5 2 N	0 1	Yes 2	No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 Inpatier	t 2 ER/Out	tpatient		Other:	ing Home 5	Reside	nce 6	Other:	
on of ending Pheath. or: After the funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month Day Ye Apr 20, 2007	y 28b. Ti ar) 0725	ime of Inju hrs	· ·	y at Work? es 2 ✔ No	28d. Describ Driver auto				
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no determin	ot be 28e. Place of Inju			factory, office bu	uilding, etc.	or Town,	. State)		or Rural Route N	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge, deat	h occurre	d at the time, dat	e and place, ar	Route 26 ne	use(s) and	d manner as	oad, Sykesville stated.	, MD
To th within To th		one) 2 Medical Examine 29b. Signature and title of certifier	er:On the basis of exam and manner stated.	ination and/or inv	estigation/	n, in my opinion,		at the time, dat	te and pla	ce, and due	to the cause(s)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month Pay Year) 2007 32 Registrar's Signature

29b. Signature and title of certifier

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 21, 2007

Olga Azoroui Kirimloglou

Kirimloglou

2. Date of Death

April

Dav

19,

2007

Montgomery

14. Race - American Indian.

Black, White, etc.

Specify: White

Own Home

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

April 20, 2007

4c. County of Death

Greece

3. Time of Death

Birthplace (State or Foreign Country)

Asia Minor

10d. Inside City Limits

Approximate Interval Between Onset and Death

11 Yes 2 No

10:20 PM

1. Decedent's Name (First, Middle, Last)

Olga

Physician

10

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nlhea

Cynthia M. Williams,

ORIGINAL

H0058032

6001 Muncaster Mill Road, Rockville, Maryland 20855

State Registrar

			For State Registrar	State of M	arylan	d / Depa <i>Cer</i>	irtment of F <i>tificate of</i>	lealth ar <i>Death</i>	nd Mental Hy	/giene 2 (Reg. No.	007	12909
- As	Dharis		1. Decedent's Name (First, Middle	e, Last)					2. Date of D	eath		3. Time of Death
	Physic /Medi		Marjorie H. Keh	ne					Month April	20, 200	Year 7	14:45 M
	Exami		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, c	r Location of E			ty of Death	1210.0
			Holy Cross Hosp	ital			Silver			Monte	omery	
1000	Funeral		5. Social Security Number	6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days		Min. (Month, D	rth av. Year)		place (State or Foreign
	Director		579-38-4860	المالا كيها	82	Yrs.		1.00.0	Feb. 1.	5, 1925	Washi	ington D.C.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation				1	Ind India City I was
	Maryl f sho ed a	5	Maryland Montg	omowie								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the 1 28a- notifi	Director	10e. Street and Number	Omery	PIT	ver Sp	10f. Zip Code			10 0:::		
	with 3a or 1 be			na de						10g. Citizen of	What Cour	itry?
	ms 2;	Funeral	13717 Nalls Cou		Ever in U.	S. 13 V	20904	lispanic Origin	2 (Specify Vos or Ne	U.S.A.	ice - Americ	ean Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Yes, specify Cub	an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)		ack, White,	etc.
Maryland 21215-0036	2 hou atura cal E	ed	15. Decedent	's Education		16a, Decede	ent's Usual Occup	ation		16b. Kind of E		
7	in "in 7.	Completed	(Specify only highes	t grade completed)		(Give k life. D	ind of work done O NOT use retired	during most of	working	TOD. KING OF E	ousiness/inc	lustry
7	d with giene r tha the l	E O	Liementary/Secondary (0-12)	College (1-4or 5)+)	Homema	ker			Own Ho	me	
פ	othe othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	, Maiden Surna	me)	
<u>a</u>	uld b Menta rked ric e	ToE	Charles Lloyd H	utson				Marjor	ie Jarvis	}		
a	and I		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailing	Address (Street	and Number o	r Rural Route Numb	er, City or Town	, State, Zip	Code)
Σ.	and salth		Marjorie M. Kyr	iacou / Daug	hter				ilver Spr			
ore	of He		20a. Method of Disposition		20b. PI	lace of Dispos	ition (Name of atory or other place		Date	20c. Location		
Ĕ	Pag nent ant: I	1	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	1	-	rematorium	, hib:	2007	Bethesd	la Ma	and and
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		21. Signature of Funeral Service	inense	4				neral Home/	Pockrille	Tro	Lylenia
m	8 9 E 8 9).3.	3	M0089	96 300	W. Mont	gomery	Ave. Ro	ckville	, MD	20850-2805
			23a. Part1. Enter the sease, or shock, or he in fail re. List of	complications that caused	the death						,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or conditio	Sepsis							3	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):						
	Examiner			Pneumoni		,						
1412	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):						
1	nd	Examiner	that initiated events	C								
Ď,	e exe	Щ.	resulting in death) Last	Due to (or as a	consequ	ence of):						
09/89	tificate be executed g physician and as the burial-transit	ledical	,	d								
		Mec	IF FEMALE:							_		
Ž Q	death cert e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth	2 🗌 Fetal	death 3 E	Ectopic pregnancy				te of deliver	-
5	the de y the a sched f	/sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	ath 5 🗆 (Other (specify)			Mo	onth	Day Year
<u>,</u>	hat ti d by fetac	문	Part II. Other significant condition	ne contributing to don'th bu	at not requi	lting in the cond	lands dans a service of		I as and			
Š.	w requires that the dependence of the should be detached	þ	Acute renal fai		it not resul	ang in the unc	errying cause give	н III Рап I,				e cause of death?
	requ	etec	Acute rener re-	LLUIE					_ '''	Yes 2 No	3∐ Proba	ably 4 Unknown
ec Lec	g 25 0	Completed							24a. Was autop	an 24b.	Were autop	osy findings available inpletion of cause of
- i	cate ; pag	Ö.							perfo 1∐ Yes	rmed?	death? 1 ☐ Yes :	•
VILAI	certif ector	Be	25. Was case referred to medical examiner?	Hognital					Death (Check only o	ne)		
5 7	this aldir	P L	1 ☐ Yes 2 ☐ No 27. Manner of Death			R/Outpatient		4 LI Nursin	g Home 5 ☐ Resid)
	After After fune	<u>0</u>	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	now injury occur	red	
2	death death ctor: / the	cat	2 Accident investiga 3 Suicide 6 Could no	ot be	n. At hom	form -1		/es 2 □ No				
3	after after in by	Certification:	4 ☐ Homicide determin	28e. Place of inju- building, etc	(Specify)	ne, rarm, stree	t, factory, office		28f. Location (S City or Ton	Street and Numb vn, State)	er or Rural	Route Number,
-	ours ours eleral		29a. Certifier 1 ☑ Certifying	Physician: To the best o	f my know	lodge death o	and at the time					
	To the respiral or tatending Prystician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medica	(Check only 2 Medical E	xaminer: On the basis of and manner stat	examinatio	on and/or inve	stigation, in my op	oinion, death o	ccurred at the time,	cause(s) and ma date and place,	anner as sta and due to	ited. the cause(s)
į	To the comp	ğ	29b. Signature and title of certifier	1	11		29c. License	number		29d. Date signe	d (Month, D	Day, Year)
				pe, pa	N		D6530	5		April 20	200	7
	10		30. Name and address of person w	ho completed cause of de	ath (Item 2	23a) (Type, Pr	int)					
	10		Nabila F. Khan,	ar ar			Road, S	ilver S	Spring, Ma	aryland	20910	
	Stat Registra	٠,	31. Date filed (Month, Day, Year)	32. A gistra	_	ire	10					
	- registic		APR 2 3	7007 1 100000		10	14/2 /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7, per fh 2866 4-24-07 vt State of Maryland Department of Health and Mental Hygiene 29 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 6:00P L. Lau April 18, 2007 Margaret 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Mitchellville Villa Rosa Nursing Home

Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other treumatic event, the Madical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Pnysician /Medical Examiner Division of Vital Records, P.O. Box 68760,

For State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriat-transit

	1 M 2 DF	e (In yrs. last birtho	i Months i Da		Min.	Date of Birth (Month, Day, Year, Dec 20, 19	Co	hplace (State or Foreign untry) tucky
	577 48 3316 XX							and traile Chattinha
	10a. State 10b. County	10c. City, Town o	or Location					10d. Inside City Limits
ţō	Maryland Prince George	Fort	: Washing	ton				1 ☐ Yes 2 ☐ No
rec	10e. Street and Number		10f. Zip Co			-	itizen of What Co	•
0	7913 Carey Branch Drive	e	20	744		Un:	ited Sta	tes
era	11 Marital Status 12. Was Decedent		13. Was Decedent If Yes, specify	of Hispanic O	rigin? (Specif	y Yes or No-	14. Race - Ame Black, Whit	
ᆵ	Armed Forces? 1 Never Married 2 Married 1 Yes, Site 1	No				ari, oto.,	Specify:	
þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 7	No Specify	y. 		Specify.	White
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual D Give kind of work d life. DO NOT use r	ccupation one during mo	ost of working	16b. l	Kind of Business	/Industry
npie	Elementary/Secondary (0-12) College (1-4or	5+)					NASA - R	etired
Son	12 4	Aei	rospace T			First, Middle, Maide		CELITOR
Be	17. Father's Name (First, Middle, Last)				Lu1u		Theirine	2
ဥ	Joseph Robert Will	inger		-		Route Number, City		
	19a. Informant's Name/Relationship (Type, Print)	196. 1	Mailing Address (S 1513 Pea	rtree (Court.	Bowie, M	D 20721	
	Robert Joseph Lau (Son)	20h Place of [Location - City or	Town, State
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		Disposition (Name, crematory or othe			2007	nton, MI	
	4 □Donation 5 □ Other (Specify)	Resi	urrection	Ceme	tery	Funeral H		
	21. Signature of Funeral Service Licensee					d, Clinto		20735
	Mrus Moors moors	57					11, 110 2	Approximate
٠.	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	iine.						Interval Between Onset and Death
ì		oscleroti	ic Cardio	vascula	ar Dise	ease		Years
		s a consequence of						V
L	Sequentially list conditions. b.	ic Atrial		ation				Years
le l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of	1):					
E	Cause (Disease of injury that initiated events c. resulting in death) Last Due to (or a:	s a consequence of	0.					
ě	Due to (or a.	s a consequence o	•)•					
lca	d							
by Physician/Medical Examiner	IF FEMALE: 23c. If yes, outcom	e of pregnancy					23d. Date of de	elivery
Lan Lan	23b. Was decedent pregnant in the past 12 months?	2 Fetal death at time of death	3 ☐Ectopic preg 5 ☐ Other (spec				Month	Day Year
VS	1 Yes 2 No 9 Unknown							
4	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cau	se given in Pa	art I.			to the cause of death?
d be						1 ☐ Yes	2 No 3 □ F	Probably 4 Unknown
						24a. Was an	24b. Were	autopsy findings available o completion of cause of
Comple						autopsy performed	? death?	es 2 No
				26. Pl	ace of Death	(Check only one)		
B	examiner?	tient 2 ER/Out	toatient 3□ DOA	0+		e 5 Residence	6 □Other (Sp	pecify)
P		niury 28b. T		. Injury at Work?		8d. Describe how in		
100	1 Matural 5 ☐ Pending (Month, D	Jay rear) II	njury M	1 ☐ Yes 2	No			
60	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I	Injury - At home, far	rm, street, factory.	office	2	8f. Location (Street City or Town, St	and Number or i	Rural Route Number,
1	4 Homicide determined building.	etc."(Specify)						
Madical Cartification.	29a. Certifier (Check only 2 Medical Examiner: On the basis	st of my knowledge	, death occurred a	the time, date	and place, a	nd due to the cause	e(s) and manner	as stated. ue to the cause(s)
15	(Check only 2 Medical Examiner: On the basis and manner	stated.						
13	29b. Signature and title of certifier	1 10		License numb	- 0	29d.	Date signed (Mo	nta, Day, Year)
	Katha	1000	((IV)	201	08	9	11910	/
	30. Name and address of person who completed cause o							
	Rakesh Arora, M.D. 143			ne, #22	22, Bov	vie , MD		
ate	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	Could A					
tra	APR 2 3 2007 States	strar's Signature						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10139 am Karen Joyce Ludford /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rosedale
Under 1 Year | If Under 24 Hrs. Baltimore Franklin Square
5. Social Security Number 6. Se Hospital Center If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 K F 49 March 11,1958 Maryland 214-72-6196 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ◯XNo Maryland Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 319 St. Georges Road 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Book Keeper Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Gravitt Joyce Fox ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Ludford, III (Husband) 319 St. Georges Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory, Ind. 04/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licen 1407 Old Eastern Avenue, Essex, Maryland 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Arrhythmia **Physician** Maligant disease of condition resulting in death) /Medical Due to (or as a sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Vascular Disease requires that the death certificate be executed rterioscleratic or Vital Records, P.O. Box 68760, nding physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year for in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autopsy 2 No certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 1 ☐ Yes 2 No 3□ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore Michael 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For Amend #19a, perFF	State of Ma H, g866, 4/2	aryland / Depa 3/07 ^{TT} Ce	artment of I	Health and Death	d Mental I	Hygiene Reg. No	2007	12912
	Physici		1. Decedent's Name (First, Middle, Last,					2. Date of	Death	-	3. Time of Death
	/Media			VIN		T		APRI	L ()	F 005 2	L 11:20 YM
7	Examir	ier	4a. Facility Name (If not institution, give.	HOSPCTA	_		or Location of D			. County of Dea	
	Funeral		5. Social Security Number 6. Sec	7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 I				rthplace (State or Foreign ountry)
С	Director		220-07-9457]M 2 X)F	85 Yrs.	Months Days	Hours N	Min. 06/1	Birth Day, Year, 4/192	1	MD
Т	and **		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Maryl	ţ	MD BALTIMO)RF	REISTERS	TOWN					1 ☐ Yes 2 X No
	r 28s	irec	10e. Street and Number	,,,,	KETOTEKO	10f. Zip Code			10g. Ci	tizen of What C	ountry?
	th wit	Funeral Director	304 CANTATA COURT	Γ , ΑΡΤ. 30)2	211	136			USA	
	r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origina Dan, Mexican, Pr	? (Specify Yes or uerto Rican, etc.	r No-	14. Race - Am Black, Whi	
36	rs afte	by Fi	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	lo i	1 □ Yes 2 🛣 No				Specify:	WHITE
21215-0036	d within 72 hours after death with the Maryland Jene. r than "natural", or ltems 23a or 28s-1 ehow the Medical Examinat must be notified at	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. K	(ind of Business	s/Industry
215	Bn "n	Completed	(Specify only highest grad	e completed) College (1-4 or 5	life.	kind of work done DO NOT use retire	during most of ed)	working			
2	filed will Hygien thar th	Con	8	1		MEMAKER	· · · · · · · · · · · · · · · · · · ·			OWN	HOME
Maryland	B E D	Be	17. Father's Name (First, Middle, Last)					Name (First, Mic	ddie, Maider		
Ž	should ind Men marka umatic	ပ	ISRAEL 19a Joformant's Name/Belationship (Tv	na Print)	FRI EDMAN	ng Address (Stree	I DA	r Rural Route Ni	imher City	GOLD	
≥	nd 2 s lith ar 27 le r treu		19a. Informant's Name/Relationship (Ty Henry HARRY LEVIN / HU	JSBAND		-			-		WN, MD 21136
Baltimore,	ges 1 and 2 should it of Health and Mer if Item 27 ie merke or other treumatic		20a. Method of Disposition		20b. Place of Dispo			Date		ocation - City o	
Ë	mit. Pages bartment of l cortant: If It injury or o		1 🛱 Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	CONGRE	GATION	04	1/20/200	7 BA	LTIMORE	, MD
3alt	Depart Import eny inj		21. Signature of Funeral Service License	99		2. Name and Addre		SOL LEV			
	40 % e Q		Matt Cen	inations that arread						ESVILLE	, MD 21208
			23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	θ.				ry arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		CATLD (AL	INTAR	CTION				
	Examiner		Commented by the secondary).							
	P #	iner	if any, leading to immediate cause. Enter Underlying		a consequence of):						
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):						
760,	ate be executed hysicien and he burial-transit	calE		4	2 0011004201100 01).						
68760	ifficate g phy as the										
Вох	death certifica e ettending ph id for use as ti	M/us	230. Was decedent pregnant	3c. If yes, outcome a		DEctopic pregnanc	**			23d. Date of de	
П	e deal	by Physician/Med	in the past 12 months?	4☐Pregnant at		Other (specify)	.y		- 1	Month	Day Year
P.O.	hat th	Phy	9 ☐ Unknown Part II. Other significant conditions cor	atributing to death bu	at not resulting in the u	oderhing cause a	ven in Part I	230 [od tobacco	use contribute t	to the cause of death?
Division of Vital Records,	law requires that the death certifica es been signed by the ettending ph . 2 should be detached for use as th	d by	URINARY TRA		ECTION	ridoriyirig causo gi	VOITHIT GIVE.		☐ Yes 2		4
COL	w req	lete						24a. V	Vas an	24h Were a	utopsy findings available
Re	o - e	Completed						— a	utopsy erformed?	prior to death?	completion of cause of
ital	iclan: Th certificete rector, pag	Be C	25. Was case referred to medical				26. Place of	1 ☐ Ye		1 □ Ye	s 2/50/NO
) (Physiclan: this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 npatie	nt 2 ☐ ER/Outpatier	nt 3□ DOA Ot	her: 4 🗆 Nursin	ng Home 5 □ F	Residence	6 Other (Spe	ecify)
n c	ling P	inol	27. Manner of Death 1 ♥ Natural 5 □ Pending	28a. Date of Injur (Month, Day		28c. Inju Wo	ry at ork?			ry occurred	
isio	death ctor: /	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Inju	iry - At home, larm, str		Yes 2□No	29L Locatio	o (Street a	ad Number or F	dural Route Number,
Ω	after after Dirac	Certification;	4 Homicide determined	building, etc	. (Specify)	eet, ractory, onice			Town, State		idiai node Number,
	To the Hoepital or Attending Physician: Within 24 hours after death. Within 24 hours after death. Within Funeral Director After this certific completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Exami	sician: To the best of	of my knowledge, deat	h occurred at the ti	ime, date and pl	lace, and due to	the cause(s) and manner a	s stated.
	the H nin 24 tha Fi	fedicai	0710)	and manner sta	examination and/or in ted.			occurred at the tir			
	To To	Σ	29b. Signature and title of certifier	/11	MY		se number			ite signed (Mon	
,	5		20 Name and address at a second	moletod				0 h = =	APRI	12 18	2007
	5		30. Name and address of person who co			Print) F(60			TOWN	MD	21133
	Sta										
	Registr	ar	APRZ3	UU	r's Signature	THE WAY					

			1 - For State Registrar		Maryland		artment tificate			and M		Reg. No.	007	129	913
Г	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	Day		3. Time o	
	/Medic	al	Charles James 1 4a. Facility Name (If not institution, g	Meyer	ner)		4b. City, To	own or	Location o	f Death	April 2		2007 County of Dea	6:00	P ^M
	Examir	er	6506 Blackhead Ro		,		Middl						altimor		
	Funeral			Sex 7	. Age (In yrs. la	* /	If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Date)			rthplace (State Country) Cyland	or Foreign
	Director		216-44-1810	1 ∑ M 2□F	62	Yrs.		54,5	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		08/01/	1944	Mai	rylánd	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	City Limits
	Mary a-f eh	ţ	Maryland Baltimon	re	Midd	lle Ri	ver							1 🗆 Yes	s 2. ₹ No
	ith the	Director	10e. Street and Number				10f. Zip C					•	zen of What C	Country?	
	72 hours after death with the Maryland neturel", or Iteme 23a or 28a-f ehow Acal Examiner must be notified at	rall	6506 Blackhead Ro					1220					S.A.		
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2€ Married	12. Was Deced Armed Ford 1 \(\text{Yes} \) 2	es?	. 13.1	Was Decede f Yes, specif	int of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	- 1	14. Race - Am Black, Wh		
036	urs at	출	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	_		l∐Yes 2ă	ØNo	Specify:				Specify: Wh	nite	
5-0	be filed within 72 hours after death with the Marylan tat Hygiene. Be other then "neturel; or iteme 23s or 28s-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's I (Specify only highest g	Education rade completed)		(Give	ient's Usual kind of work	done d	uring most	of worki	ng	16b. Kir	nd of Busines	s/Industry	
121	within 6ne.	mp	Elementary/Secondary (0-12)	College (1-4	for 5+)		oo not use ce Tea					Vend	ding		
d 2	filed Hygie other		17. Father's Name (First, Middle, Las	it)		DCIVI	00 100			r's Name	(First, Middle,				
Maryland 21215-0036	Aental Aental rked c	To Be	Bernard Francis	Meyer					Dorot	hy M	Minerva	o'c	onnell		
lan	s 1 and 2 should if Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship								Route Numbe				^
6,₹	of Health of Health litem 27		Laura Meyer (Wife	⊇ <i>)</i>	20h Pla		BLACK sition (Name		a koa		ate Tamoi		Maryıar cation - City o	nd 21220	J
Ö	ages nt of th :: # ite		X⊠Burial 2 ☐ Cremation 3		ate Cer	metery, cren	natory or oth	ner place			3/2007				5ac l
Baltimore,	permit, Pages I Department of H important: if ite eny injury or ot paget.		4 Donation 5 Other (Spec		HOI									e, Mary	Lanu
B	Depa impo eny i	1	1			1	407 ol	Br ld E	uzdzi aster	nski n Av	Funera enue, F	al Ho Essex	ome, P. k, Mary	A. Zland 2	1221
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that car y one cause on eac	used the death.	Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rrest,		Approxima Interval Be	etween
	Physician	ů	Immediate ause (Final disease or condition resulting in death)	a. Carc	inoma	3-	LUNG	1						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseque	ence of);									
		-e	Sequentially list conditions, if any leading to immediate	b. Due to (o	r as a consague	ence of):									
1	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
8760,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (o	r as a conseque	ence of):									
3876	physic physic s the b	dicai		d										-	
Box 6	eath certific attending p I for use as I	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								2	23d. Date of de	elivery	
	death le atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2 Fetal on nt at time of dea		Ectopic pred Other (spec						Month	Day	Year
P.0	that the de ed by the a detached to	Phys	9 Unknown								50 - Did .	-			44-0
Vital Records,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the buriat-transit	Ď	Part If. Other significant conditions	contributing to dea	th but not resul	ting in the ui	nderlying cau	use give	in in Part I.				se contribute □No 3□F	to the cause of Probably 4	death? jUnknown
ecc	alawr has be	Completed	<u></u>								24a. Was autop	DSV	prior to	utopsy findings completion of	s available cause of
alF	n: The licate har.										1 ☐ Yes	rmed? 2€ No	death? 1 ☐ Ye		
ξ	Physicien: 'this certificaral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	patient 2□E	D/Outpation	4 20004	Othe			Check only o				
o	g Phy er this eral di	H .	27. Manner of Death	28a. Date of (Month)		28b. Time of		c. Injury Work	4 140	-	ne 5 Nescribe h			өсіту)	
ion	tending Fleath. tor: After the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	on	Day rear)	Injury	М		7 ′es 2 □ 1	No S					
Division of	d or Attending after death. Director: After in by the funer	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place o	f Injury - At hon g, etc. (Specify)	ne, farm, str	eet, factory,	office		-	28f. Location (5 City or Tox			Ru <i>ral R</i> oute Nui	m <i>ber</i> ,
	To the Hospitel or Attending 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the baseminer: On the base	is of examination	ledge, death on and/or inv	occurred at vestigation, i	t the tim in my op	e, date and inion, deat	d place, a	and due to the e	cause(s) date and	and manner a place, and du	is stated. le to the cause	(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier						number				. •	הth, Day, Year)	
•			Harry o.	replu	MI		i)20	663	†		4/	21/07		
	8		30. Name and address of person who	completed cause	of death (Item :	23a) (Type.	Print)	At :	311	Th	ween	mn	2/2	04	-
	Sta	ite	BARY JoJePvt > 31. Date filed (Month, Day, Year)	76 U	gistrar's Signatu	reg ,	Locali .	,			1	, ,,			
	Registi		APR 2 8	76.0 32. Rs	ASSES -	No. V									

Registrar

State

11065 Little Patuxent Pkwy. Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Clement B. Knight, M.D.

31. Date filed (Month, Day, Year)

			For State	State of	of Maryla		artment of H		Mental Hy	0.0	107	10015
		ą	Registrar 1. Decedent's Name (First, Midd	lle, Last)		Ce	Tillicate of t	Dealli	2. Date of De	Reg. No.	JUL	3. Time of Death
4.2	Physici /Medic		CHARLES			CMA	v Sc.		Month	20ay	O 7	0945 M
	Examin	er	4a. Facility Name (If not institution 7127 Ohio Ave.	n, give street and nu	ımber)		4b. City, Town, or Hanover	Location of Deat	h	_	nty of Death Arunc	lo]
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthr	place (State or Foreign
£s.	Director		216-16-1124	108 M 2□ F	84	Yrs.	Months Days	Hours Min.	4/22/1		MD	nry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	ý	10c. 0	City, Town or Lo	ocation	-			1	0d. Inside City Limits
	a-f sh	ctor	MD Anne	Arundel	Han	over						1 ☐ Yes 2 🙀 No
	with the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		*
	death v	Funeral	7127 Ohio Ave.		edent Ever in		21076 Was Decedent of H	ispanic Origin? (S	pecify Yes or No)- 14. R	USA ace - Americ	
36	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorce	Armed Formed Formed Tried 1-7 Yes, G	2 No		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puer Specify:	to Rican, etc.)	В	ack, White, E ^{ify:} Whit	
5-0036	2 hour atural ca Ex	ted k	15. Decede	nt's Education	Dates:1943	16a, Dece	dent's Usual Occup	ation		16b. Kind of		
215	ithin 7: ne. nan "n	Completed	Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)		kind of work done of DO NOT use retired		rking	INTAC		
2	filed w Hygier ther th		12 17. Father's Name (<i>First, Middle</i>	(last)		Furnac	e Technic	18. Mother's Nar	ne (First Middle	HVAC	ame)	
Maryland 2121	should be filed nd Mental Hygi marked other matic event, t	To Be	Howard Herbert					Lillie (, waidon ourn	amey	
lary	ss 1 and 2 should be Health and Ments item 27 is marked other traumatic events.		19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number or Ri	ural Route Numb	er, City or Tow	n, State, Zip	Code)
	ss 1 and of Health item 27 other tr		Gloria Mollman 20a. Method of Disposition	/ Wife	20h		Ohio Ave.		er, MD 2	1076 20c. Location	City or To	Owin State
altimore,	- -		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (State	cemetery, cre on Ceme	osition (Name of matory or other place	· i		Elkrido	•	
alt	permit. Pag Department Important: I any Injury o		21. Signature Funeral Service				L. Kat L. Kat 50 Washir					
n	89 = 89	Ji d	Hamily	14/2	101378						MD 21	
	Dhomisian	9	23a. art1. Enter the disease of shock, or heart failure. Lis	t only one cause on	caused the de each line.	atn. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to	(or as a conse	equence of):						yean
	Examiner		Sequentially list conditions,	b								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events	Due to	(or as a conse	equence of):						
o,	execu an and rial-tra		that initiated events resulting in death) Last	cDue to	(or as a conse	equence of):						
8/60	cate be executed physician and the burial-transit	dical		d								
9	certific nding p	/Me	IF FEMALE:	23c. If yes, ou	itcome pf preg	nancy				234 [Date of delive	an,
. Box	at the death certifier by the attending I tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live	birth 2□Fe nant at time of	tal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			1	nonth	Day Year
J.	at the	Phys	9 ☐ Unknown Part II. Other significant condit			aulting in the u	ndorlying anyon aive	on in Dort I	Day Did	abassa yas sa	maniht. a 41	and an analysis of decays
Vital Records,	The law requires that the te has been signed by th vage 2 should be detache	by	Part II. Other significant condit	ions contributing to c	eath but not re	esulting in the u	ndenying cause give	en in Part I.	23e. Did 1			ne cause of death? eably 4 Dunknown
000	law rec	Completed							24a. Was	an 24b	o. Were auto	psy findings available mpletion of cause of
r m		Com							perfo	psy ormed? 2 A No	death?	
<u> </u>	s certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ER/Outpatie	nt 3 DOA Othe	or.	ath (Check only o			
יסר	ig Phy ter this	\vdash	27. Manner of Death	28a. Date	···	28b. Time o		4 Nursing F	28d. Describe	dence 6 Co		y)
SIO	tendin eath. tor: Af the fur	catio	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation			M 1□	Yes 2 □ No				
Division or	lor At after d Direct J in by	Certification:	4 Homicide deterr	mined 286. Place	e of injury - At ling, etc. <i>(Spe</i>	home, farm, sti c <i>ify)</i>	eet, factory, office		28f. Location (City or To	Street and Nur wn, State)	nber or Rura	al Route Number,
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certification the Funeral director, to ompletely filled in by the funeral director, to		29a. Certifier 1 Certifyi (Check only 2 ☐ Medica	ing Physician: To the	e best of my k	nowledge, deat	h occurred at the tin	ne, date and place	e, and due to the	cause(s) and i	manner as s	tated.
	the H	Medical	one)	and mar	ner stated.		29c. License		arred at the time,			
	7 × 7 0		29b. Signature and title of certific	2 Deta	wta	M	LOC. LIGHTSE		38	29d. Date sign	120/0	7
	104		30. Name and address of person	who completed cau		em 23a) (Type,	Print)	11	1	11	- /	M A
	100		MICHAR J.L	CLENTA			Print) EYENSE	MG HW	Ay /+	NAP	ULIS	Mo 21401
	Sta Registr		31. Date filed (Month, Day, Year)	. A	Registrar's Sig	IK A	ask I					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 201 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death U Day Year **Physician** 8;30 A.M 18, Frank D. Moser April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FutureCare Cherrywood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 213-01-7766 **Director** 89 June 14, 1917 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No **Funeral Director** MD Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 4 Gwynnbrook Ave. 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Baltimore County Courts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence L. Moser ပ္ Nellie Benson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jain A. Trader 6 Gwynnbrook Ave., Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Evergreen Mem. Garden's 4/20/07 Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Un Eline Funeral Home Reisterstown, MD 21136 ans Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Im rediate Cause (Final disase or condition ulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in resolute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant condition uting to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title ertifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

State Registrar

30. Name and address

31. Date filed (Month, Day, Year)

en

			For State Registrar		State of M	aryland	-	irtment of tificate of	Health and <i>Death</i>	Mental	Hygier Reg. 1	0007	12917
		-	1. Decedent's Name	(First, Middle, La	st)					2. Date Mont	of Death	Day Year	3. Time of Death
	Physicia /Medic			John E	rnest McO	Carthy				Apr		2007	7:05 A M
	Examin		4a. Facility Name (If r	_	·				or Location of Dea	ath	4	c. County of Deal	
			14513 Elr 5. Social Security Nur			(la la	d brindlender o	Silve:	Spring	rs. 8. Date	of Birth	Montgome	
	Funeral Director		577-22-73	24	IMM 2□F	ge (In yrs. las	Yrs.	Months Days		n (Mon	h. Dav. Yea	1921 Wasi	thplace (State or Foreign buntry) hington, D.C
	aryland show d at	_		10b. County			Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	8a-f	ecto		Montgom	ery	S	llver	Spring			140		
	with t	Funeral Director	10e. Street and Numb		rt			10f. Zip Code	20906			Citizen of What Co ited Stat	
	leath	era	11. Marital Status		12. Was Decedent	Ever in U.S.	13. \		Hispanic Origin?	(Specify Yes		14. Race - Ame	
0000	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel"; or teems 23a or 28a-f show int, the Medical Examiner must be notified at	b	1 □ Never Marrier 3 □ Widowed 4		Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	1 -	fYes, specify Cu I∐Yes 2∭X No		èrto Rican, et	c.)	Black, Whit	e, etc. nite
2	72 ho natur ilcal	eted	(Specif	15. Decedent's Ed y only highest gra	ducation ade completed)		16a. Deced	lent's Usual Occ	upation e durina most of w	vorkina	1	Kind of Business/	
V	ithin ne.	Completed	Elementary/Second		College (1-4or	5+))/////////////////////////////////////	DO NOT use retir tor of B	e during most of w red) Suilding	9	1	ited Sta	
7	lled w Hygiel her tl nt, th	ਠੌ	17. Father's Name (F	iret Middle Last	4	(Opera	tions	18. Mother's N	ame (First M		vernment	
מום	d be f	Be C	John Albi							ıh Irer			
<u></u>	should nd Mark mark imati	ဥ	19a. Informant's Nan				19b. Mailin	g Address (Stree	et and Number or	Rural Route I	Number, Cit	y or Town, State, 2	Zip Code)
Z Z	alth ar		Patrick E.	McCarth	y / Son	2	405 St	turbridg	e Drive,	Medin	a, 0h	io 44256	
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-4 show eny injury or other treumatic event, the Medical Examiner must be notified at once.				Removal from State			sition (Name of natory or other p norial Par	1 175PT	Date :i1 23,		Location - City or	
	permit. Departm Importa eny Inju		21. Signature of Fundament	eral Service Lice		401305	Roi 300	Name and Add Dert A. Pu West Mon	ress of Facility Imphrey Fun Itgomery Av	eral Hor	ne/Rock	cville, Inc. e, Marylan	d 20850–2805
т	4		23a. Part1. Enter the	e disease, or com	plications that cause one cause on each I	d the death.	Do not ent	er the mode of d	ying, such as card	iac or respira	tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Fi		Prostat		cer						Onset and Death
	/Medical Examiner		resulting in death)		_a	a conseque							
	Examiner	<u></u>	Sequentially list cond if any, leading to imm	ditions,	b	a conseque	noo of\:						The state of the s
	ted .	nine	Cause. Enter Underly Cause (Disease or in	neglate ying ijury	Due to (or as	a conseque	rice or).						
,	execunate and al-train	Examiner	that initiated events resulting in death) La		C. Due to (or as	a conseque	nce of):						
0/00	icate be executed physician and s the burial-transit	dical		•	d								
0	rtificat ng phy as th												
O. BOX	requires that the death certific een signed by the attending p nould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	leath 3□	Ectopic pregnar Other (specify)			_	23d. Date of de Month	livery Day Year
7	that the		Part II. Other signific	cant conditions	contributing to death I	out not resulti	ing in the u	nderlying cause o	given in Part I.	23e.	Did tobacc	o use contribute to	the cause of death?
2	quires n sign	d by								_	1 ☐ Yes	2 X No 3 □ P	robably 4 Unknown
ecords,		Completed								24a.	Was an	24b. Were a	utopsy findings available
Ľ	sician: The law s certificate has t irector, page 2 s	шо								-	autopsy performed Yes 2 🔀	? death? No 1 ☐ Yes	completion of cause of 2 □ No
VIII	ian: artifica ctor, p	Be C	25. Was case referre	ed to medical					26. Place of D				
200	Physician: r this certific ral director,	To	1 Yes 2 N	lo	Hospital: 1 ☐ Inpati	ient 2 EF	R/Outpatien	t 3 DOA	ther: 4 🗆 Nursing	Home 5 🛚	Residence	6 □Other (Spe	ocify)
	o 0 0		27. Manner of Death 1 X Natural	5 Pending	28a. Date of Inj (Month, Da		8b. Time of Injury	W		28d. Des	cribe how ir	jury occurred	
SION	Attending r death. ector: Afte	cati	2 Accident 3 Suicide	investigatio	e 280 Place of in	ium. At hom	o form atr	M 1	☐ Yes 2 ☐ No	006 1	ti /Ctt		-/8-
2	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	4 Homicide	determined	building, e	tc. (Specify)				City	or Tòwn, St	ate)	ural Route Number,
	the Hosp in 24 hou the Fune	ledical	(Check only 2 one)	2 ☐ Medical Exa	hysician: To the best miner: On the basis and manner s	of examination	edge, death on and/or in	vestigation, in m	y opinion, death or	ace, and due courred at the	time, date	and place, and du	e to the cause(s)
	vitt To	Σ	29b. Signature and ti	itle of certifier	70				nse number			Date signed (Moni	
1			1600	Jan June	tonger	~ W	0		3459		Ap	ril 19,	2007
	12+1		30. Name and address	Taubman	, M.D. 1	8109 P	rince		Drive, #	275, 0	Olney,	Marylan	d 20832
R	Sta Registr		31. Date filed (Month			rar's Signatu							
DHI	MH 17 Rev 1/2		AF	PR 2 3 20	107 Janear	w St.	100				-		

		1 - For State Registrar		faryland /		rtment of F			eg. No.	007	12918
Physici	an	Decedent's Name (First, Middle, Las.	1)					2. Date of Deat Month	h Day	Year	3. Time of Death
/Medi		CHARLES				MILLE		April	18	2007	8:12 P M
Examir	ner	4a. Facility Name (If not institution, give		,			Location of Dea	th	4c. Cou	inty of Death	
		Sinai Hospital				If Under 1 Year	Himore If Under 24 Hrs			N/A	
Funeral		5. Social Security Number 6. Se	X X M 2 □ F	ge (In yrs. last b	Yrs.	Months Days	Hours Min	. (Month, Day,	Year)	9. Birthp	place (State or Foreign htry)
Director		Usual Residence of Decedent		95	11.0.			06/14/	1911		POLAND
land		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
Mary Herb	ģ	MD BALTIM	ORE	BALT	IMOF	₹F					1 Tes 2 No
r 28a	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
h with		6656 SANZO ROAD				212	n 9		US <i>F</i>	1	
ours after death with the Marylan raf', or Iteme 23a or 28a-f ehow Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden	2	13.			Specify Yes or No- to Rican, etc.)	14. F	Race - Americ	
or Ite	Ī	1 ☐ Never Married 2XX Married	Armed Forces 1 XYes 2 If Yes, Give	T T WWP ^N		r Yes, speciny Cuba I□ Yes 2 🛣 No	Specify:	to Rican, etc.)	1	Black, White, a <i>cify:</i> WH]	
ours Fig.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	: """		1 195 2121110	эрөспу.		Spe	cify: WПJ	
"netural",	Completed	15. Decedent's Edi (Specify only highest grad		16	(Give	lent's Usual Occup	during most of wo	orking	16b. Kind <i>o</i>	f Business/Inc	dustry
dithin	m idu	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retired	1)		0.5	OCEDY.	
o filed within 72 hours after death with the Maryland I Hygiene. other then "netural", or lieme 23s or 28s-1 show vent, the Modical Exeminat must be notified at	ပိ	17. Father's Name (First, Middle, Last)		Į įv	IANA	EK	40.14-15-4-11-	(Fine 1814 the		ROCERY	
ed a b	Be							me (First, Middle, I	walden Sun		
2 should be and Mental le marked (aumatic ev	ျ	SAMUEL	0.1.1		LER		JENNY			WACHTE	
- C	ř	19a. Informant's Name/Relationship (T)	•	1				ural Route Number			Code)
Heali Heali em 2 ther		IDA MILLER / WI 20a. Method of Disposition	rt			SANZO RO	AD, BALI			on - City or To	own State
Pages nent of int: If It		1 1 Burial 2 □ Cremation 3 □1		BE	TH T	FTI OH	ce)		Loo. Loouin	on ony or re	, olute
permit. Page Depertment of Important: If any Injury of once.	8 8	4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Pineral Service Licens		CONGR	EGAT	ION Name and Addre	04/2			IMORE,	
Depe Impo any I		21. Signature of American Service License					3	OL LEVINS			
	-	23a. Part1. Enter the disease, or composhock, or heart failure. List only	lations that cause	ad the death. Do				ROAD - F		ILLE,	MD 21208 Approximate
Physician /Medical Examiner bullet site private and bullet start transit start transit start sta	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	s a consequence	9 Of):	ibrillatio	SCASC				
artific ing pl		IF FEMALE:		-						1.	
law requires thet the death certific. as been signed by the attending pl 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal deat at time of death		Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
thet hed by deta		Part II. Other significant conditions co	ntributing to death	but not resulting	in the ur	derlying cause giv	en in Part I.	23e. Did tot	acco use c	ontribute to th	ne cause of death?
uires sigr ld be	d by	Hype	tension					1 □ Y€	s 2 No	3 □ Pr <i>o</i> b	ably 4 Munknown
w requires that been signed b should be deta	Completed	71						24a. Was a	24	h Were auto	psy findings available
The la	Ę							autops	y	prior to con death?	mptetion of cause of
in: T ificate or, pa	e Co	25. Was case referred to medical						1 ☐ Yes 2	₽ No	1 ☐ Yes	2 No
Physicien: The law this certificate has t ral director, page 2 s	00	- Coming of	Hospital: 1 ☐ Inpat	ient 2 KER/C	hader = 1	Oth		ath Check only on		0.1	
Phys r this aral di	٦: T	27. Manner of Death	28a. Date of Inj (Month, D		Time of	3 DOA	4 Nursing r	dome 5 ☐ Reside			γ)
ding f th. After funer	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	28c. Injur Wor	k? Yes 2 ∐No		,,,,,		
Atter dea octor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At home,	farm, str	eet, factory, office		28f. Location (St	reet and Nu	mber or Rura	I Route Number,
efter Direction din b	Certification:	4 Homicide determined	building, e	etc. (Specify)		and the late of th		City or Town	, State)		
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Atter to completely filled in by the funeral	Medical C	29a. Certifier 1 S Certifying Phy (Check only one) 2 Medical Exem	rsician: To the bes iner: On the basis and manner s	of examination a	ge, death ind/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, d	use(s) and ate and plac	manner as si ce, and due to	lated. the cause(s)
withir To th comp	W.	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date sig	ned (Month,	Day, Year)
1		1	7	M.O.		^	059062		A 1	18,2	200
2		30. Name and address of person who co		-) (Type,	,	059062			10,2	
		Chad Housen,	MB 240	I W Be	Ived	ere B.	Iti more	MD 212	15		
Sta	to	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature		0					

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #8 per FH g866 4/27/07 JH ertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 18, 2007 **Physician** April 9:17 A^{M} Ella E. Moscariello /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1930 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 76 217-24-9072 April 30, 1939 Director Illinois Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 🏋 No Maryland Harford Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or Items 23a or event, the Medical Examiner must be re Funeral 336 Princeton Lane 21014 U.S.A. death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othin any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Maurice Taylor Marie Huelett ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, MD 21014 Anthony Moscariello (Husband) 336 Princeton Lane Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison VA Cemetery 04-23-2007 Owings Mill, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neuvonia /Medical Due to (or as a consequence of): **Examiner** ongestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine Due to (or as a consequence of): 1800 43(01) 14 18 07 09 17 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an HT pertension 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Aly Naguib, HD

31. Date filed (Month, Day, Year)

HAT SELECT

Drive Suite 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Colgale

32. Régistrar's Signature

Do05 9387

Forest Hill, MD 21050

4/19/07

ORIGINAL

		1- For State of Maryland State of Maryland	•	artment of H		, ,	ene g. No 2 0 0 7	12921
Physicia	an	1. Decedent's Name (First, Middle, Last)	1 0 1 1			2. Date of Death		3. Time of Death 9:30P M
/Medic Examin		Ruby Potts 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	9.301 "
ZXXIIIII		3503 Chadwick Court		Temple			Prince Ge	orge's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 1 Age) 1 Age (In yrs. In 2 XXX 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 19,	Year) 9. Birthp 1927 Virg	lace (State or Foreign try) 1n1a
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation			1	0d. Inside City Limits
Mary B-f sh	ţo	Maryland Prince George	Temp	ole Hills				1 ☐ Yes XX No
h with the 23a or 28	ai Directo	10e. Street and Number 3503 Chadwick Court		10f. Zip Code 20748			nited State	-
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funerai	11. Marital Status 1 Never Married Married 12. Was Decedent Ever in U.s Armed Forces? 1 Never Married Married In Yes, Give	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 又又 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, Specify: In	
tural;	ed by	3 Widowed 4 Divorced Year or Dates:		AA dent's Usual Occup		1	6b. Kind of Business/Inc	
Maryland 21215-UU36 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other then "natural", or treumatic event, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give	kind of work done of DO NOT use retired	during most of work	ing	Own Home	2030 y
be filed tal Hygin d other	BeC	17. Father's Name (First, Middle, Last)	Homer			e (First, Middle, M		
	٥	Richard C. Bryant			Inez I			
		19a. Informant's Name/Relationship (Type, Print) Donna Solis (Daughter)	208 I	Barberry	Drive, Wi	1mington		
Page Page nent o		4 Denniel OV Compation 2 Demonstran Comp	ace of Dispo metery, cren e Crema	sition (Name of natory or other place atory	^{e)} Apri 2007	1 22	oc. Location - City or To Clinton, Mar	
Departit. Departit imports		21. Signature of Fundral Service Licensee	_	. Name and Addres Lexandria			Home,Inc 6 ton, MD 20	633 01d 735
Physician		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	. Do not ent		g, such as cardiac		1	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequ	ence of):	10301	<u> </u>			
uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	ence of):				1	
icate be executed physicien and sthe burial-transit	al Exa	resulting in death) Last Due to (or as a consequ	ence of):					
OS/ tificate ng phy: as the	ledical	d		****				
the death certificate be executed by the attending physicien and lached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
s a s t s	6	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.		acco use contribute to the	e cause of death?
ecord law requir as been si 2 should I	letec					24a. Was an		
The lay	Completed					autopsy perform	prior to con	osy findings available inpletion of cause of 2 No
VICIAN: The ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?		0#		h Check only one		
this ai di	ion: To	27. Manner of Death Natural 5 Pending 1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injun Worl	4 Nursing no	me 5 Resider 28d. Describe hov	nce 6 Other (Specify w injury occurred	')
f or Attending after death. Director: After din by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hose building, etc. (Specify.	me, farm, str		103 2 1140	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my know and manner: On the basis of examination and manner stated.	rledge, death on and/or inv	rectumed at the time restigation, in my of	ia date and place pinion, death occur	and duallo the dai red at the time, dai	usa(s) and manner as st te and place, and due to	ated the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licenso	number	29	d. Date signed (Month,	Day, Year)
		10000	\wedge	16/0	0391	091	4/2-	0/02
3		30. Name and address of person who completed cause of death (Item B. RED) AEE UY 67	010	3 ml	AV	Surg	W H:113	20148
Stat Registra		31. Date filed (Month, Day, Year) APR 2 3 2007	ure do	WEST THE STATE OF				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death

OF WELL	
	Physician
1	/Medical
清	Examiner

Funeral Director

with the Maryland show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at death \ filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than ırry or other traumatic event, the Me Injury or other Department of F Important: If ite any Injury or ot once.

Physician

Baltimore, Maryland 21215-0036

/Medical Examiner The law requires that the death certificate be executed and burial-trar physician the attending pl for use as t been signed by the should be detached certificate has b rector, page 2 s To the Hospital or Attending Physician: funeral director, this After nours after death.

neral Director; Al
filled in by the fur within 24 hours a

To the Funeral C

completely filled

Division or Vital Records, P.O. Box 68760,

A Month 1. Decedent's Name (First, Middle, Last) Time of Death Day Jesse Saunders 0021 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Hos Laure aguir. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number unk 9. Birthplace (State or Foreign Country) Unk 6. Sex (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 1 M 2 □ F Yrs. 55 Mar 6, 1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director MD Prince George's Laure1 unk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? unk Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: þ white 3 Widowed 4 Divorced Completed unk unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7300 Van Dusen Road Laurel, MD 20707 Laurel Regional Hospital 20b. Place of Disposition (Name of come ery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ronald S. Wade 22. Name and Address of Facility Ŋi State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1 Enter the disease, or complications that cause of shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cau (Final disease or condition resulting in death) Arterioscheutik Due to (or as a consequence of) Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1. Natural M 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 23

gistrar's Signature

07-03037 Zeolinda Shuler	State 1- For State	or Print in Black In of Maryland / Depa		alth and Ment	al Hygiene	200	17 1292
Physician/	1. Decedent's Name (First, Middle,Las	it)			2. Date of Dea		3. Time of Death
Medical Examine	ZEOLIND 4a. Facility Name (if not institution, give			y, Town, or Location of	Month April 20, 1	2007 4c. County of Deat	0712 hrs
<u>f</u>	University Hospital	o stroot and nambor,		timore		N/a	
Funeral Director	BI 1 0B 3007	ex 7. Age (In yrs. la		Inder 1 Year If Under onths Days Hours	Min.	irth(MM/DD/YYYY) 9. Bi Forei . 21 , 1955 ^{Co}	
any	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	MD. N/A		BALTI	MORE			1 X Yes 2 No
the Maryland n or 28a-f shr tiffed at once	10e. Street and Number	•	10f.	Zip Code		10g. Citizen of What Cou	intry?
ith the 23a or notific		PRING AVE. 12. Was Decedent Ever in U.	S. Tab Was Day	21211	in 2 / Conside Van an N	USA	iona Indian Dinak
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	1 Never Married 2 Married	Armed Forces? 1 Yes 2y No	If Yes, sp	edent of Hispanic Origi ecify Cuban, Mexican,		White, etc.	rican Indian, Black,
urs aftetural".	45 Decided Education (Constitution	If Yes, Give Year or Dates: nly highest grade completed)		2 X No specify:	ind of work done	Specify: E	BLACK /Industry
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	working life. DO NOT t	use retired)	METROPOL MAINTENA	ITAN
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)			s Name (First, Middle,	Maiden Surname)	
1121 Id be fil fental Is recent,	JAMES PRICE 19a. Informant's Name/Relationship (Type Print \	10h Mailine Adds	LOF	RETTA ZER	RVOS Imber, City or Town, Stat	7: 0:40
MD 21 d 2 should dith and Me n 27 is ma aumatic ev	SHARICE SHULI					ALTO, MD. 2	
re, N I and Health Fitem	20a. Method of Disposition	20b. I	Place of Disposition (I crematory or other pla	Name of cemetery,	Date	20c. Location - City o	
Pages Pages nent of ant: I	1 Burial 2 Cremation 3 4 Donation 5 Other Specify	- Removal month State		· ·	APR.26,2	07 BALTI	MORE, MD.
Baltimore, permit, Pages I an Department of Hee Important: If ite	21 Anature of Funeral Service Lice		22. Name a	and Address of Facility	CRUGGS FU	NERAL HOM	E
Physician	23a. Part I. Enter the disease, or com	Dications that caused the de in.	1 1.41	2 F DREC	TO MOT	BALTO MD	21213 Approximate Interval
/Medical	failure. List only one cause on e Immediate Cause (Final disease a	ch line.					Between Onset and Death
(taminer	or condition resulting in death)	Due to (or as a consequence of					
9	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):		-		-
ted nisit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of	f\·				
ecuted and transit	events resulting in death) Last		1).				
e execcian arcian arrial - tr	X UNPENDED	AMENDED #23a,27,perME,g8	369. 7/19/07	TT			
68760, ertificate be executing physician and east the burial - tra	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy			23d. Date of deliver	•
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E	past 12 months? 1 Yes 2 No 9 ✓ Unknow	1 Live birth 4 Pregnant at time of de	2 Fetal dea ath 5 Other (S		pregnancy	Month	Day Year
O. E at the c d by the stacked		contributing to death but not re	esulting in the underly	ving cause given in Par	rt I. 23e. Did	tobacco use contribute to	the cause of death?
S, P.O. irres that th rigned by d be detach					1 Ye	es 2 V No 3 Pro	babiy 4 Unknown
ords aw requas beer as beer shoul					24a. Was	ppsy prior to	utopsy findings available completion of cause of
Records, The law require. Finger has been signed by agge 2 should by Completed						ormed? death? 2 No 1 V	es 2 No
ital sician: s certificactor.	25. Was case referred to medical examiner?	Hospital: 1 V Inpatient 2	ER/Outpatient 3	26.Place of Death (Check only one) Nursing Home 5	Residence 6 Other	
of V g Phys fter thii neral di	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	н.
ion tendin eath. tor: A the fu	1 X Natural 5 Pending 2 Accident Investigat			1 Yes 2	No		
Division of Vital Records, spital or Attending Physician: The law requirmeral Director: After this certificate has been sifilled in by the funeral director, page 2 should t Certification: To Be Completed	3 Suicide 6 Could not	be 28e. Place of Injury - At he	ome, farm, street, fact	ory, office building, etc	28f. Location or Town,	(Street and Number or R State)	ural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	4 Homicide determine 29a. Certifier 4 Certifier Physics	(0,000.0)/	no doubt	the time data and			to d
To the Hos within 24 h To the Fur completely	(Check only	ian: To the best of my knowledger: On the basis of examination at		· · · · · · · · · · · · · · · · · · ·			
Ne general	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mo	onth, Day, Year)
4	Maryone M	eStrell		O.C.M.E.		April 21, 2007	
Α,	30. Name and add ess of person who	completed cause of death (Item	23a)				

State Registrar

Margarita Korell MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Shaver Frances 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A MOY Date of Birth (Month, Day, Year) 05 31 1926 Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security **Funeral** Months Days 1 ☐ M 2 💢 F 86 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MDBaltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Abunaton \mathbb{I} Avenue 21220 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Black 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Salesperson permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Ross Department Store 10th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wise Louise Conquest ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaver Seymour Place Gwynn Oak, MD 21207 **Carol** Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/23/07 Baltmore, MD 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Volughn C. Greene Funeral Services aughn 5151 Baltimore National Pike Balts. MD 21229 23a. Part1. Enter the rilisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, wheart filtere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** upal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine be executed burial-transit Due to (or as a consequence of): the attending physician requires that the death certificate the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Ö 9□Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law page 2 autopsy perform this certificate 1∐ Yes Vital To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 9 completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation after death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanni 32. Begistrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

ome S	ingleta		State of Maryland / Department 1- For State Certificate Registrar		nd Mental		g. No. 20	07 1292
	hysicia Exami	an/	1. Decedent's Name (First, Middle, Last) Jerome Single	tary		2. Date of Death	n Day Year	3. Time of Death 0317 hrs
			Facility Name (if not institution, give street and number) Maryland Correctional Institute - Roxbury	4b. City, Town, o Hagerstow		eath	4c. County of Death Washington	n
	ineral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $218-62-1179$ $12 M$ $2 F$ 53) If Under 1 Year Months Day Yrs.		N. 45-	3-/954 GC	rthplace (State or gn Maryland buntry)
*	w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo					10d. Inside City Limits
() // Maryland	23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code	229	10	g. Citizen of What Cou	
h with the	ems 23a oi t be notifi	Funeral Di	11. Marital Status 12. Was Decedent Eyer in U.S. 13.		ispanic Ongin?	(Specify Yes or No-	14. Race - Amer White, etc.	rican Indian, Black,
s after deat	ral", or it	by Fun	3 Widowed 4 Divorced If Yes, Give Year or Dates.	Yes 2 No	o specify:		Specify:	Black
), MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	dental Hygiene. narked other than "natural", event, the Medical Examiner	Completed		dent's Usual Occupa g most of working life			16b. Kind of Business	
5-0036 iled within 7:	lygiene. other th	E O	17. Father's Name (First, Middle, Last)		18.Mother's N	ame (First, Middle, M	laiden Sumame)	inknown
1215 d be file	and Mental Hygiene. 7 is marked other thatic event, the Med	Be	marvin E. Singletary		Don	othy 13	riggs	
MD 21 d 2 should	27 is m matic	٩					ber, City or Town, State Balto, nd	
	nent of Health and N ant: If item 27 is n or other traumatic		20a. Method of Disposition 20b. Place of Dis	position (Name of ce	emetery,	Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages 1 ar	Department of F Important: If injury or other		4 Donation 5 Other Specify: Trunto 21. Signature of Funeral Service Licensee	Cemel	ery	1-28-07	HILTON F.	k, md.
Balti permit.	Depart Impor injury		21. Signalute of Funeral Service Licensee	Tarupin	ss of Facility	270 Fred Runeral	HILTON For	to, md, 2,229
	sician edical		23a. Part I Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying	, such as cardi	ac or respiratory arre	st, shock, or heart	Detricen Onset and
	miner		Immediate Cause (Final disease or condition resulting in death) a. Ligature strangulation Due to (or as a consequence of):					Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
uted	and - transit	l Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
O, s be exec	siciar	edical	X UNPENDED #23a,27,28a-f, perME,g	369, 7/26/07	7 TT			
Box 6876 death certificate	e attending phy for use as the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pre	egnancy	23d. Date of delive Month	ry Day Year
. Boy	by the att ached for	Physi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the		aivon in Part I	23e Did to	bacco use contribute to	the cause of death?
s, P.O	signed be det	2		ne andenying cause				bably 4 V Unknown
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed	ate has been age 2 should	Completed				24a. Was a autop: perfor	sy prior to med? death?	
al R	certificate ector, page	Be C	25. Was case referred to medical examiner?	26.Plac	ce of Death (Ch	eck only one)		
f Vit	di d	2	examiner? 1 Very Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		Other N		Residence 6 Other	er: Scene
on o	ath. or: After t the funeral	tion:	1 Natural 5 Pending Pending Poly (Month, Day, Year) Find At		Yes 2 No	outh death		round his neck
Division	cours after death neral Director: filled in by the	Certification	2 Accident Investigation Investigation 3 X Suicide 6 Could not be determined (Specify) cell	street, factory, office	building, etc.	or Town, S		orstorn MD
o the Hosp	within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investant manner stated.			and due to the caus-	e(s) and manner as sta	ited.
	≱ ⊢ 00	₩.	29b. Signature and title of certifier		nse number		29d. Date signed (M	onth, Day, Year)
			30. Name and address of person who completed deure of death (Item 23a)	0.0	.M.E.		April 18, 2007	
			Theodore M. King, Jr., MD. Assistant Medical Examine	111 Penn S	treet, Baltin	nore, MD 21201		
	St Regist	ate trar	31. Date filed (MoAir Pay Year) 2007 32. Figistrar's Signature	house				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Item: 2 per M.D G-866 4/21/00 ertificate of Death 2. Date of Death 4/12/07 1. Decedent's Name (First, Middle, Last) **Physician** GEORGE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 401 East 25th. Street Apt. 11J Baltimore 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 213-62-8070 51 12/14/1955 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 401 East 25th. Street Funeral Apt. 11J 21218 U.S.A. 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Š 'natural", the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) A 27 Is marked other than "1 traumatic event" Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Donald Starkes Sr. Martha Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonce. 4105 Belvieu Avenue, Baltimore, Maryland 21215 Martha Starkes / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Park Ceme. 04/21/2007 | Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licenses 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final JABETIC COMPLICATIONS **Physician** -O MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): PEICTENS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ARDIOVASCULAR ISCHEMIC DUSEASE To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 TYes 2 TNo Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 2 4 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 DNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

IMOND

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D37370

1000 E. EAGER ST. BALTO. MO 21202

APRIL 16, 2007

			For State Registrar	State of	f Maryland / Dep <i>Ce</i>	artment of l		nd Mental Hy	giene Reg. No 200	7 12927
ı	Physic		1. Decedent's Name (First, Middle		Stalling	7		2. Date of De Month	Day Yea	3. Time of Death
	/Medi Examir		Harry 4a. Facility Name (If not institution,	Lee give street and nun		4b. City, Town,	or Location of		4c. County of De	ath
			Franklin Squar 5. Social Security Number			HO5e		4 Hrs. 8. Date of Bi	Ba/tim	ore
	Funeral Director		212-28-1861	1 M 2 F	7. Age (In yrs. last birthday, Yrs.	Months Days		Min. (Month, D. 2/28/	av. Year) (irthplace (State or Foreign Country) ryland
	show sd at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	vith the Man a or 28a-f sh be notified	Director	Maryland Balti	more	Essex					1 □ Yes 2 No
	with that a or 20	Dire	10e. Street and Number	,		10f. Zip Code			10g. Citizen of What (Country?
	death w ms 23a	Funeral	316 Sassafras R	12. Was Dece	dent Ever in U.S. 13.	21221 Was Decedent of	Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	U. S. A.	nerican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Health and Mental Hygiene. The firen 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	2 No	1 ☐ Yes 2 ☒ No		Puerto Rican, etc.)	Specific	
5-0036	72 hours "natural"; edical Exa	ted b	15. Decedent	Year or Da s Education	16a. Dece	edent's Usual Occu	pation		16b. Kind of Busines	hite s/Industry
72	within 7; iene. than "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1		e kind of work done DO NOT use retire				
d 21	filed w Hygier ther th	S	12 17. Father's Name (<i>First, Middle, I</i>	_ast)	Tech	ological nician		s Name (First, Middle	Civil Def	ense
Maryland	2 should be filed v and Mental Hygie Is marked other t raumatic event, th	To Be	James F. Stalli	,				ude Josenl	•	
7 fary	2 shou and N Is mai		19a. Informant's Name/Relationsh	ip (Type. Print)		-			ber, City or Town, State	
1.2	es 1 and 2 s of Health ar item 27 is rother trau		Frances Virgini 20a. Method of Disposition	<u>a Stallin</u>	gs (Wife) 3 20b. Place of Disp cometery, cre	16 Sassat		ad Essex	, Maryland 20c. Location - City	
altimore,	Pages nent of i nnt: If ite		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State cemetery, cre Oak Lawn		1	4/25 2007	Baltimore,	_
276 Balti	permit. Pages 'Department of Important: If ite any Injury or of once.		21. Signature of Funeral Service I	icensee	2	2. Name and Addr	ress of Facility			
/ 🖁	205 20		23a. Part1. Enter the disease, or shock, or heart failure. List	convolication that c				neral Home n Avenue		yland 21221 Approximate
	Physician	П	shock, or heart failure. List of Immediate Cause (Final disease or condition	only one choice on e	ach line.	,		,		Interval Between Onset and Death 5 days
	/Medical Examiner	П	resulting in death)	Due to (as a consequence of):	1000				Julys
	ža į	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	07				
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence of):					
,09	ate be executed sysician and he burial-transit	ical E)	,	d Due to (or as a consequence or).					
Box 68760,	ntificate ng phy as the		IF FEMALE:	- u.						
Bô	death certifica attending ph d for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b		□Ectopic pregnan	су		23d. Date of o	lelivery Day Year
P.O.	at the de by the a	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unkno						
	signed d be de		Part II. Other significant condition	ns contributing to de	eath but not resulting in the t	underlying cause g	iven in Part I.		tobacco use contribute Yes 2 X No 3□	to the cause of death? Probably 4 □Unknown
eco	e law requ has been je 2 shoul	Completed						24a. Was	s an 24b. Were	autopsy findings available o completion of cause of
a B	ifcian: The lav certificate has ector, page 2.3							peri 1∐ Yes	ormed? death 2A No 1 □ Y	?
Zit	ystciai s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2 ☐ ER/Outpatie	ent 3 DOA O	ther:	of Death <i>(Check only</i> sing Home 5 □ Res	one) sidence 6 □Other (S)	necify)
o uo	ding Physician: h. : After this certific funeral director,	tion: T	27. Manner of Death 1 Natural 5 □ Pending investig	28a. Date (Mont		We		28d. Describe	how injury occurred	
Division or Vital Records,	l or Attenc after death Director:	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 20e. Place	of injury - At home, farm, si ng, etc. <i>(Specify)</i>	treet, factory, office	9	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical I	Examiner: On the ba	best of my knowledge, dea asis of examination and/or i ner stated.	th occurred at the nvestigation, in my	time, date and opinion, deat	I place, and due to the h occurred at the time	e cause(s) and manner e, date and place, and d	as stated. lue to the cause(s)
	To the within 2 To the comple	Me	29b Signature and title of certifier	an de	roler		15e number	7	29d. Date signed (Mo	onth, Day, Year)
	10+1		30. Name and address of person	who completed caus	e of death (Item 23a) (Type	, Print)		2	/L' Mar 4	11 212 20
	Sta		31. Date filed (Nonth, Day, Year)	Andersa 2007	e of death (Item 23a) (Type n 9000 Frau egistrar's Signature	ale sq	uare !	stive pa	I FI MUTE, FO	461631

			For State	State of Marylar	-					ental F		0.0	07	1000	3 (
			Registrar 1. Decedent's Name (First, Middle, Lasi	Certificate of Death Reg. No. 2							10. <u>(</u> U	UI	1636	. (
	Physicia /Medic		Jean C.	Wels					April 1 17 pay 2007 yea			Y <i>e</i> ar	3. Time of Death 8:10PM		
	Examin		4a. Facility Name (If not institution, give Southern Marylan				4b. City, Town, or Location of Death Clinton				4c. County of De Prince			orge's	
	Funeral Director	100	5. Social Security Number 6. Se 215-56-7673	7. Age (In yrs.		If Undo	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of (Month, Feb.	Birth Day, Yea	2926	9. Birthp Court West	lace (State or Fore	ign a
			Usual Residence of Decedent	140- 0	T						,				
950	Aarylar F show ed at	ō	Maryland Prince George's Clinton							1	0d. Inside City Lim 1 □ Yes 2√1				
	r 28a-f	irect	10e. Street and Number	corge 3			ip Code				10g. C	Citizen of W		itry?	_
	tth witl 23a o ust be	ralD	9115 Stacey M. L	ane		:	20735					U.	S.A.		
	irs aner dea il", or Items kaminer m	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ W dowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	f Yes, sp	edent of Hi ecify Cuba 2023 No	spanic Origin, Mexican Specify:	gin? (Sp <i>e</i> n, Puerto I	cify Yes or Rican, etc.)	No-		, White,	an Indian, etc. White	
3-003a	72 hou natura dical E	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Deced	dent's Us	ual Occupa	ation	t of workir	na -	16b.	Kind of Bus	siness/Inc	dustry	
717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If filem Z1 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurse		use retired	luring most)	t of Workii	'y	Nι	ırsing	3		
<u>a</u>		To Be (17. Father's Name (<i>First, Middle, Last)</i> Car1 Har	r					r's Name Bess			eter	e)		
lary	2 shour and M Is mar	-	19a. Informant's Name/Relationship (T		1							or Town, S			
e,	1 and Health em 27		Rick Welshans (So								<u> </u>	yland			
	Pages ent of nt: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ I		Place of Dispo cemetery, cren ington	Nat	ona1	Cem.	pri1° 20	07	A	clingt	on.	Virginia	
Dallillor	permit. I Departm Importar any Inju		21. Signature of Funeral Service Licens		22	. Name	and Addres	s of Facilit	_{ty} Le	e Fun	eral	Home,	Inc.	on, MD207	
			23a. Part1. Enter the disease, or comp											Approximate Interval Between	_
ė.	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events								Onset and Death				
F.	/Medical Examiner										_				
	D #	ner													
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):															
Due to (or as a consequence of): Sequentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):															
	ertificat ng phy e as th	Medi	IF FEMALE:												_
.O. DOX	the death ce y the attendi iched for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aideath 3□	Ectopic Other (pregnancy specify)				_	23d. Date Mon		ery Day Year	
ν, Γ	ires that signed b	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying	cause give	en in Part i.	•	}		-		ne cause of death?	
cords,	1 Yes 2 No 3										Probably 4 Unknown				
ב	The la ate has page 2	1								eath?	psy findings availat npletion of cause of 2 No	f			
VII	stan:	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check on		10		Z DE IVO	_
> 5	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 🗆 🖸	OA Othe	er: 4□Nu	ırsing Hor	ne 5 🗆 R	esidence	6 □Othe	r (Specif	y)	
			27. Mannet of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury Work 1 🗆 `	/ at ⟨? Yes 2 □ l		28d. Descril	oe how in	jury occurre	ed		
	al or Atter s after dea al Director	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)							er or Rura	l Route Number,				
	e Hospit 24 hour e Funera letely fille	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To th withir To th comp	Me								29d. C	29d. Date signed (Month, Day, Year)				
)			* Kame	20033720 77777.0							8 20	7			
1	70		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard Palmen MD 132 & Junthern avenue SE Sink 310 Washington 20 20032												
f	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 200	32 Registrar's Sign	ature										

ORIGINAL

		For	State of Maryla				lental Hyg	giene			
		State Registrar		C	ertificate of	Death		Reg. No.	117	12020	
Physicia /Medic		Decedent's Name (First, Middle, Las John Th	,	e, Jr	•		2. Date of Dea Month April	18°, 2		3. Time of Death 17:14 M	
Examine Funeral Director	er	4a. Facility Name (If not institution, give Southern Marylar 5. Social Security Number 6. S 218-16-2001	d Hospital	s. last birthda Yrs.	Cli	ntoni If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da) Dec . 1	Prin	9. Birth	n eorge 's nplace (State or Foreign untry) aryland	
		Usual Residence of Decedent 10a. State 10b. County	Location		116	10d. Inside City Limits					
or 28a-f sh	Director	Maryland Prince (Clinton 10f. Zip Code			1 ☐ Yes 2 🖾 No I. Citizen of What Country?					
Hygiene. ither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	y Funeral Directo	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 943 ─			2C 3. Was Decedent of H If Yes, specify Cub. 1 □ Yes 2 🗷 No	1735 dispanic Origin? (Spean, Mexican, Puerto Specify:	14. R	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White			
e. an "natural"; Medical Exa	Completed by	3 Nidowed 4 □ Divorced 15. Decedent's Er (Specify only highest gra Elementary/Secondary (0-12)	ducation 16a		6a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Chauffer		ing	16b. Kind of	Kind of Business/Industry ilitary/transportat		
ਲ ਪ ≶	Be Con	17. Father's Name (First, Middle, Last)							ame)	-	
of Health and Mental Hygi item 27 is marked other other traumatic event,	10	, , , , , , , , , , , , , , , , , , , ,					Bernice Elizabeth Dennison d Number or Rural Route Number, City or Town, State, Zip Code)				
		Nancy Walkup (Data 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific Control of the Co									
Department Important: If any injury or once.		21. Signature of Funeral Sovice Licer	"/		22. Name and Addre	ess of Facility Lee		1 Home	, INC		
ysician and with physician and saminer transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unicerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. ACUTE RENAL FAILURE Due to (or as a consequence of):								Approximate Interval Between Onset and Death ADMITTED ON 4/10/07 EXPIRED ON 4/18/07 17/20 MRS	
ittending or use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lov.				te of delivery onth Day Year				
been signed by the s should be detached f	by	and start significant contained so the start of the start						Did tobacco use contribute to the cause of death? 1⊌Yes 2□No 3□Probably 4□Unknown			
his certificate has be I director, page 2 sh	Completed	autopsy prior performed? deal 1 Yes 2 MN 1 □							prior to death?	e autopsy findings available r to completion of cause of th? Yes 2 \(\square\) No	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1							curred		
24 hours e Funeral	Medical Co		t⊟ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ✓ 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.								
within To th comp	Me	29b. Signature and title of certifier	29c. Licen. ▶ 3	se number		Date signed (Month, Day, Year)					
ôtl		30. Name and address of person who SATISH JUMANI,	M.D. 10,57	- PAT		e, Suite	, wall	ORF, M	(A 20	603.	
Sta Registr		31. Date filed (Month, Day, Year) APR 2 3	32. Registrar's Sig		Condis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month April 15, **Physician** 2007 7:00 a M Dennis Walters /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 12017 Dove Circle Laurel Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 x M 2 □ F 83 May 14, 1923 256-44-7394 Georgiá Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20-4-4 any injury or other traumatic event, the Marter 1 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Director Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States America 12017 Dove Circle 20708 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 k No Specify: ģ WHite 3 X Widowed 4 ☐ Divorced Year or Dates: unk Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Research Technician Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Storey Richard Tilmar. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75087 1608 South Alamo Dallas Frank Walter/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2007 Crownsville Veteran Cem. Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal e on 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 Approximate Interval Between Onset and Death 4 HOURS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cluse Government of the conditions o Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ OCCLUSIVE PERIPHERAL ARTERIAL 1 ▼ Yes 2 No 3 Probably 4 Unknown icate has been signated to page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2∑No certificate 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 【☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

GelBL MD

14201 CAUPER

D17502

State Registrar

WA-1

Registrar

31. Date filed (Month, Day, Year)

HOREY KURTPITY

251

32. Registrar's Signature

EAST ANTIBYAH

STREGT,

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April April 6 HDay **Physician** 5,70A M 2007 Plummer Alexander /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 13 altimore Washinghon mechical (2) m Burnit who 8. Date of Birth (Month, Day, Year) Tilly 15, 1919 6. Sex 1 M 2 □ F If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Country 87 279-18-0963 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State e how permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 ehow amp injury or other treumatic avent, Ita Madical Exarcitival Inval be notified at once. 1 ☐ Yes 2X No Crofton Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2421 Old Mystic Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑X'es 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Court Clerk Circuit Court 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leila Plummer John H. Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2410 Chelmsford Dr. Crofton, MD. Mark D. Alexander / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Forest Hill Cemetery 04/12/2007 Boston, Mass. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee Bowie, MD. 6512 NW Crain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any leading to introduce cause. Enter Underlying Cause (Disease or injury that intlated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25/No 1□ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 1 patient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending after death.
Director: Afi 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) Ş 29b. Signature and tille of certifie 30. Name and address of person who completed callise of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type of State

or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007	10000
e of Maryland / Department of Health and Mental Hygiene	15333

		1- For State Registrar		Certific	ate of	Death		, 5	Reg	g. No.		
Physiciar Medical Examin	n/	Decedent's Name (First, Middle, Carlos Ramiro	Lopez Aguir	re				A	Date of Death Month pril 13, 20	Day	Year	3. Time of Death 1425 hrs
		4a. Facility Name (if not institution, Anne Arundel Medical C	-			. City, Town, o		of Death		4c. C Ani	ounty of Death ne Arundel	
Funeral Director		531-12-9001	Sex 7. Age X M 2 F	(In yrs. last bir	thday) Yrs.	If Under 1 Ye Months Da		_	Date of Birth		Готоів	thplace (State or gn untry) Guatema1a
á	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	1						10d. Inside City Limits
d how a		Maryland Montgo	mery	Silve	r Spr	ing						1 X Yes 2 No
he Marylar ior 28a-f s	Director	10e. Street and Number 12629 Layhill I	Road #T2			10f. Zip Code 2	0906		10	_	of What Cou atemal	
leath with	Funeral	11. Marital Status 1 X Never Married 2 Marr	ed 12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S.		Decedent of H	n, Mexican	, Puerto Rica	in, etc.)		White, etc.	can Indian, Black,
s after ral",	2	L	ed If Yes, Give Year or Dates:	D. 140				Guate			ecify. Whi	
21215-0036 hould be filed within 72 hours after and Mental Hygiene is marked other than "natural", the event, the Medical Examine.	톃	15. Decedent's Education (Specification Elementary/Secondary (0-12)	conly highest grade com			Usual Occupa t of working life			aone	160. KIN	d of Business/	industry
136 hin 72 e than '	Completed	3rd	Odliego (1-4 of o	· .	Const	ruction	1			Se1	f Empl	oyed
5-0C ed wit tygien other ihe M	녌	17. Father's Name (First, Middle, La	ast)				18.Mother	's Name (Firs	st, Middle, M	aiden Su	rname)	
121 De fil Durtal H rrked vent, 1	æ	Felicito Lopez						a Lid:				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	ို	19a. Informant's Name/Relationship Edwin Lopez/brot			<u>Silve</u>	r Sprin	ig, Ma	rylan	d, 209	106	or Town, State	
or Hea		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta	te crema	tory or othe			Da			cation - City or	
Page Page ment tant:		4 Donation 5 Other Spec		Famil:	_				-2007		temala	
Baltimore, permit Pages I an Department of Her Important: If ite njury or other tr	1	21. Signature of Funeral Service Li	egyfsee	025								me, Inc. D.C. 20010
Physician /Medical		22 . Part T. Enter the disease, or do railure. List only one cause or	each line.	the death. Do	ot enter the	mode of dying	, such as c	ardiac or res	piratory arre		_	Approximate Interval Between Onset and
Examiner	4	Immediate C se (Final disease or condition resulting in death)	a. Hypertens		oscler	otic card	liovasc	ular di	sease			Death
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse									
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of j.								
e execularian and ial - tra	Medical	X UNPENDED	dAM#255ED27,pe			′07 TT						
3760, ficate be or g physicia s the buria	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom			I death 3	Ectopic	c pregnancy		i i	Date of deliver onth	y Day Year
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certifing After this certificate has been signed by the attending inneral director, page 2 should be detached for use as the control of the statement of the control of the statement of the control of the statement of	Physician	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at	مادم مات کے سیانہ		er (Specify)	Lotopic	o programay				
O. For the at the d by the stached		Part II. Other significant condition	s contributing to death	but not resultir	ng in the un	derlying cause	given in Pa	art I.				the cause of death?
ires the signe	ارة الق							_ 1	1 Yes	21		babily 4 <equation-block></equation-block>
Division of Vital Records, P.O ral or Attending Physician: The law requires that is after death. al Director: After this certificate has been signed belied in by the funeral director, page 2 should be detacted in by the	Completed	S							24a Was a autops	sy .	prior to	utopsy findings available completion of cause of
Reco	E								perform 1 V Yes 2		death? 1 ✔ Ye	es 2 No
ian:	BeC	25. Was case referred to medical examiner?				26.Plac		(Check only	one)			
F Vit	٥	1 Yes 2 No		nt 2 🗸 ER/C				Nursing Ho		Residenc		r:
n of ding J a. Afte		27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Inju (Month, Day,Y		Time of Inj		ury at Work Yes 2	.	I. Describe h	ow injury	occurred	
Division of Vital Recipital or Attending Physician: The Jours after death. The Jure of the This certificate Internal Director: After this certificate Internal Director, page	Certification:	2 Accident Investi	gation 28e Place of In	iury - At home t	farm street				Location (S	treet and	Number or Ru	ural Route Number, City
Divi	뛽	3 Suicide 6 Could determ	not be	, a. ,		, , , , , , , , , , , , , , , , , , , ,			or Town, St			
hou hou	Medical Co	29a. Certifier 1 Certifying Phy	sician: To the best of my									
To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licer	se number			29d. Da	te signed (Mo	nth, Day, Year)
		1/11	1/400 -	7		0.0	M.E.			April 1	14, 2007	
		30. Name and address of person w	ho completed cayse of d	eath (Item 23a)	1							
R (3)		Theodore M. King, Jr., I			niner ´	11 Penn S	treet, Ba	Iltimore, N	/ID 21201			
Sta Registr		31. Date filed (Month, Day Year) APR 1 7 2007	32. Registra	r's Signature	W							

07-02808 Claus Peter Arndt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Provided Examiner Class Peter Amelia A South River Road South Fundamental Director F	
Class Peter Arndt As Facility American infalling perspection As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective As Facility American infalling perspective As South River Road South As Facility American infalling perspective As South River Road South As Facility American infalling perspective	
Funeral Director Funeral Director Fig. Social Sociality Number: Social Sociality Number: Social S	
Director Oy4-32-8846 1/X 2 F 65 7/s Months Days Hours Min 11/15/1941 Foreign New Yor Country New Yor Country New Yor Country New Yor Country New Yor Country New Yor Country New Yor Ne	
The State 10b. County 10c. City, Town or Location 10d. Inside City L 10d. Inside City	rk
Maryland Anne Arundel Edgewater 1 Ves 2 X	ımıts
48 South River Road South 11. Martial Status 11. Martial Status 11. Martial Status 11. Never Married 21. Married 21. Married 22. Married 23. Widowed 24. Married 25. Decedent's Education (Specify version very highest grade completed) 25. Decedent's Education (Specify version very highest grade completed) 26. Decedent's Education (Specify version very highest grade completed) 27. Faither's Name (First, Middle, Last) 27. Faither's Name (First, Middle, Marden Sumanne) 28. Decedent's Education (Specify version very highest grade completed) 29. Dear 19.	No
The state of the s	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
1 Burial 2 A Cremation 3 Removal from State State	
21. Signature of final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interpretation of the line of	
Physician Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Familier The standing of failure. List only one cause on each line. Between Onset Death Constitution resulting in death	on al
or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
if any, leading to immediate Let underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
The first of the control of the cont	
events resulting in death) Last Due to (or as a consequence of): UNPENDED AMENDED	
So you are using the first of t	
99 9 5 4 9 2	
past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
O fig. 1 Yes 2 No 9 Unknown o Unknown	
O so the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. O to the state of the significant conditions contribute to the cause of death significant conditions contrib	1?
Chronic alcoholism Yes 2 No 3 Probably 4 Unknown of the underlying cause given in Part	own
Thronic alcoholism 1 Yes 2 No 3 Probably 4 Unknown that the law administration of cause of the law and the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of cause of the law administration of	
Defrormed? death? 1 ✓ Yes 2 No 1 ✓ Yes	io
The state of Death (Check only one) 25. Was case referred to medical examiner? 1 Ves 2 No 1 Ves 2	
1 Ves 2 No 1 Ves	
The state of the s	
Continue of the continue of th	City
2 Accident Suicide Acci	
e se se se se se se se se se se se se se	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O, C, M.E. April 14, 2007	
Menting the freq TPs, new. 30. Name and address of person who completed cause of death (Item 23a)	
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) Registrar APR 2 3 2007	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-1	For State Registrar	Olate of ma	ryland	-	tificate of D			eg. No. 2	007	12	935
			. Decedent's Name (First, Middle, La						2. Date of Deal	Day	Year	3. Time o	of Death D M
	hysicia /Medic	al	Ruth McGowan	Brennan			4b. City, Town, or L	ocation of Death	April 6,		unty of Death		Р
E	Examin	-1	a. Facility Name (If not institution, giv Sacred Heart Home, Ir					tsville		Pri	nce Geo	orge's	
	ineral rector		. Social Security Number 6. S		(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 15,	, Year)	9. Birth Con Wisco	nplace (State untry) nsin	or Foreign
and	A		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside (
Maryl	f sho	to	Maryland Montgo	omery			Silver Spri	ng					s 21 No
the	r 28a	S -	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?	
th with	23a o	alD	9906 Forest Grove			1	20902	04-1-2 (8-	nacify Van or No.	14.	USA Race - Ame	rican Indian.	
.1215-UU36 within 72 hours after death with the Maryland ene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 YN If Yes, Give Year or Dates:		1	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2€ No	Specify:	o Rican, etc.)		Black, White		_
Z I Z I 3-003 ed within 72 hours a giene.	natura dical E	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)		16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired)	ution Juring most of work)	king	16b. Kind	of Business/	Industry	
/ithin	han "e Me	ld m	Elementary/Secondary (0-12)	College (1-4or 5	+)		memaker				Own Hor	ne	
N DO	nt, th	გ -	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	ne (First, Middle,	Maiden Su	ırname)		
yiang buid be i Mental	marked other	To Be	Henry J. McGowan					May Heml					
Maryland td 2 should be file Ith and Mental Hy	is marl aumati	-	19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street a					Zip Code)	
- 00	27 is er tra		Joan B. Wehrsted	t/Daughter			Dexter Avenu		Spring, M			Town, State	
MO Pages Tent of	4 2 4	-	20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)		of Hea	osition (Name of matory or other plac even Cemeter	y 200	10,	ilver :	-	Marylar	nd
Baiti permit. Departin	Importe any Inju		21. Signatur of Fundal Service Lic				2 Name and Address ancis J. Co 30 Universit				. MD 20	901	
// a /M	bhysician and ledical aminer sthe burial-transit	edical Examiner	23a. Part. Enter the disease, of construction of the construction	a. ATHER Due to (or as b. Due to (or as c. Due to (or as d.	a conseque	ence of):	TIC CAN	2 D10 VA	SCULA.	Q D1.	SEASE	UN.	K NOW!
. Box 6	ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal of	death 3	☐Ectopic pregnancy	У		23	3d. Date of do Month	elivery Day	Year
ds, P.	signed by the a d be detached f	by	Part II. Other significant condition $ALZHE iM$	is contributing to death b $\mathcal{E}\mathcal{R}$ \mathcal{S} $\mathcal{D}(\mathcal{S})$	out not result	ting in the	underlying cause giv	ren in Part I. YENS101		tobacco us Yes 2□		to the cause	of death? Unknowr
Records, P.O The law requires that the	page 2 should b	Completed	DEMENT						24a. Was		24b. Were prior to death?		ngs available of cause of
Vital sician: ⊺	certificate rector, pag	(a)	25. Was case referred to medical						eath (Check only	one)			
or Vital Physician:	. <u>s</u> :≣	To B	examiner? 1 □ Yes 2 No		ient 2□E		ent 3 DOA		Home 5 ☐ Res			pecify)	
	death. ctor : After th y the funeral	Certification:	27. Magner of Death 1 Natural 5 Pending 2 Accident investiga		ay Year)	28b. Time Injury	M 1]Yes 2□No	28d. Describe			Rural Route I	Number,
Division	after de I Direct d in by t	ertific	4 Homicide determin	building, e	etc. (<i>Specity,</i>	"	street, factory, office		City or 10	own, State)			
Hospita	within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 CertifyIng (Check only one) 2 Medical E	Physician: To the bes examiner: On the basis and manner s	of examinat	wledge, de tion and/or	ath occurred at the t investigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner place, and d	as stated. lue to the cau	use(s)
o the	ithin (o the omple	Med					29c, Licen	se number		29d. Date	e signed (Mo	onth Day, Yes	ar)
Ĕ	≱⊭ંઇ		> Chow	dley, mo			1 24	3/21		04	1/09	1200-	7
1	2		29b. Signature and title of certifier Chock of 30. Name and address of person w SUAUL CHOWD 31. Date filed (Mornharder, Year)	who completed cause of MPY, MD	death (Item	23a) (Typ	e, Print)	IVE; BO	LRTON	SUIL	€,1	4720	866
	S Regis	tate	31. Date filed (Morph Sey, Year)	2007 32. R			Accest 1						

			For State	State of M	laryland		rtment of H					
	_		Registrar 1. Decedent's Name (First, Middle, Last)			Cer	uncate of L	Jeani	2. Date of Deat	eg. No. 7	37	3. Time of Death
п	Physici	an		TO TO A STUDSTICS					Month	Day	Year	9:70 4M
1	/Medic		Estelle Madeline 4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of Death	MPICIL	4c. County	of Death	020
101	Examin	er	Washington County		_		Hagers				ingt	วท
-	Funeral		5. Social Security Number 6. Sex		ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
4:	Director		235-12-1648	M 2 X F	85	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 17		Vest	Virginia
	p		Usual Residence of Decedent									
	arylar show	Ļ.	10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 No
	e Ma Ba-f s	cto	Maryland Washing	ton	Вос	onsbor						
	or 2	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	What Cour	ntry?
	ath v s 23a nust	rai	20040 Benevola Ch			140.1		713	'(\/ \/		SA e - Americ	on Indian
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medleal Examiner must be notified at	Funeral	11. Wallar olacao	12. Was Deceden Armed Forces	?	. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	o Rican, etc.)		k, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:		-	I□Yes 2X No	Specify:		Specify	/: W1	ite
21215-0036	tura al E	ed	15. Decedent's Edu			16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bu		
15	in 72 n "ng Medik	Completed	(Specify only highest grade		.54)	(Give life. L	kind of work done o OO NOT use retired	furing most of worl)	king			
212	withii jiene. r than the M	E	8	0	3+)	Н	omemaker_			Her o	wn h	ome
	be filed within 72 hours after death with the Marylan ttal Hygiene. cd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle, I	Maiden Surnan	ne)	
ılar		2	Alvin Lewis Staub	S				Mary Vi	rginia G	rove		
Maryland	2 should be to and Mental is marked of raumatic ever	1	19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
	12 = Z		Rebecca L. Moser	- Daught			Benevol	<u>a Church</u>				
Baltimore,	of Hea of Hea of Item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	emoval from State	COL	ice of Dispo metery, crer	sition (Name of natory or other plac	e)	Date	20c. Location -	City or To	own, State
Ĕ	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		4 □ Donation 5 □ Other (Specify)		I		Cemetery		/07 M	artinsb	urg,	W. Va.
3all	permit. Depart Import any inj once.		21. Signature of Funeral Service Licens	mm		()22	. Name and Addres	ss of Facility	Minnich :	Funera1	Hom	е
	205 20		COU	1/////			15 E. Wil		100		[d. 2	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each	ed the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Opset And Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	31	TUCK	٧						(000g)
1	/Medical Examiner		resulting in death)	Due	s a conseque	ence of	-0.10	ø				1 Dans
8		<u>ا</u>	Sequentially list conditions,	o. Que to for a	a conseque	ence of):	eacher	7			1	o day 5
Т	nsit	Examine	Tarry, leading to withing date cause. Enter Underlying Cause (Disease or injury that initiated events	A	MILIA	now	ر الم				1	o day
,	cate be executed only sician and the burial-transit	Exa	resulting in death) Last	Due to for a	s a conseque	ence of):						
8760,	e be sicia e bur	dical		d								
9		ledi										
Вох	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it.	Physician/Me	23b. was decedent pregnant	3c. If yes, outcom			Ectopic pregnancy	,		1	te of deliv	-
	deat e att	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown	at time of dea		Other (specify)			Mo	onth	Day Year
P.0	n requires that the dibeen signed by the should be detached	h,	9 Unknown									
	es th igned be de		Part II. Other algnificant conditions co	ntributing to death	but not result	ting in the u	nderlying cause giv	en in Part I.			4	he cause of death?
ord	equir sen s	ted	July aug	IN A	1.1.	2 -			1 □ Y	es 2□ No	3 ☐ P 10	bably 4 ☐Unknown
Vital Records,	has be	Completed by	_ Chouse U	19 a	wes	2/			24a. Was a autops	SV	Were auto	ppsy findings available impletion of cause of
H		Son		/					perform 1□ Yes		death? 1 ☐ Yes	2 □ No
/ita	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?				Ī		th (Check only on	ne)		
or \	d is	2	1 ☐ Yes 2 ☐ No	lospital: 1 thpa		R/Outpatier		4 🗆 Nuising n	lome 5 ☐ Reside			fy)
ū	ding P		27. Manner h h 5 Pending	28a. Date of In (Month, E	njury Day Year) 2	28b. Time o Injury	Wor		28d. Describe ho	ow injury occur	red	
Sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	non Dines of				Yes 2 □ No	201 1 11 12			. Don't Minches
Division	after death. Director: A	Certification:	4 Homicide determined	building,	etc. (Specify)	ne, iaim, su	eet, factory, office		City or Town	n, State)	per or Hun	al Route Number,
	spital ours a neral filled		29a. Certifier 1 Certifying Phy	sician: To the bes	st of my know	ledge, deat	h occurred at the tir	ne, date and place	and due to the c	ause(s) and m	anner as s	stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Example)	ner: On the basis and manner:		on and/or in	vestigation, in my o	pinion, death occu	urred at the time, o	date and place,	and due	to the cause(s)
	To the Within To the Soump	₩	29b. Signature and title of certifier	/			290 Licens	e number	2	29d. Date signe	ed (Month,	Day, Year)
			DAMUEL (1	lan			130	062>	7	Trul	12	5007
	—		30. Name and address of person who co	and the same	death (Item 2	23a) (Type	Print)	- 4/1	D. 16	/ INIA	21	240
25	H-5		Jey East ANI	(9/1m	stall	1. fr	1110 200	1779	WITOWN	1 111)	1	170
	Sta		31. Date filed (Month, Day, Year) APR 13 20	32. Regis	strar's Signatu	ure	1					
	Regist	rar	W W T D Z(JUI JUI	an 1	7. <i>D</i>	and I					

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth Bennett Basnight 10:50 PM April 8 2007 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Julia Manor Nursing Home Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Nov 4 1914 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months 92 137-20-2130 Maryland Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County 28e-f show other treumetic event, the Medical Examiner must be notified at Washington Yes 2 No Maryland Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 333 Mill Street 21740 U.S.A. or Items 23a Completed by Funerai death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel" or item any injury or other treumetic every 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No Specify: Black 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper Self Employed 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David Bennett Ida Langford Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon H. Key (Granddaughter) 270 Potomac Heights Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Lakeveiw Mem Park Apr 17 2007 Cinnamincin New Jersey ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Ling 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Crebro voscular accident Physician 3 moulhs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed; 1 Yes 2 No To the Hospitel or Attending Physicien: after death.

Director: After this certification of the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028365 4-9-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nul Ched- Heyston 190 21740 MAN 368 31. Date filed (Month, Day, Year) State Registrar

			For Amend Item 10e State	ate of Marylar	nd / Depa	rtment of F	lealth and M	lental Hyg	iene	
			1 - State Registrar WCHD/SH 4/11/(1. Decedent's Name (First, Middle, Last))/ per FH	Cer	tificate of	Death	2. Date of Dea	eg. No.	3. Time of Death
П	Physici /Medio		Preston Luci	an Brown	1			Month April	9 ^{Day} 2007	7:20A M
	Examir		4a. Facility Name (If not institution, give street	and number)		•	r Location of Death		4c. County of Death	
		Α	Citizens Care an			Freder			Frederic	
Ü	Funeral Director		5. Social Security Number 6. Sex 1 A X	7. Age (In yrs. 82	/ast birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5/4/1	Year) Cou	place (State or Foreign ntry) ginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	ation	<u></u>			10d. Inside City Limits
	Mary -f sho fied a	ţ	Md Frederick	Fr	ederi	ck				1 ☐Yes 2 ☐ No
	h the or 28a or noti	Director	10e. Street and Number	1 2 2		10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	th wit	100 C	0 1900 Rosemont	Ave		2170	2		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	1 Never Married 2 Married 1	as Decedent Ever in U med Forces? ∐Yes 2 M No Yes, Give ear or Dates:	lf	/as Decedent of H Yes, specify Cuba □Yes 2X No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
Ö	72 hot	ted	15. Decedent's Education (Specify only highest grade com		16a. Decede	ent's Usual Occup	pation	·n.	16b. Kind of Business/Ir	ndustry
21215-0036	rithin 7 ne. nan "ı e Med	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)			during most of worki d)	ng	T	
	iled w Hygiel ther th	S	17. Father's Name (First, Middle, Last)		l Fa.	rmer	18. Mother's Name	/First Middle	Farm	
and	d be f ental F ced of	o Be	Claude Brown				Mary E	,		
Maryland	shoul nd Me mark	To	19a. Informant's Name/Relationship (Type. P.	rint)	19b. Mailing	Address (Street			r, City or Town, State, Zij	p Code)
	and 2 alth a 27 is		JacQueline Waller	(Daught)						ksburg,VA.
ore	of He filter		20a. Method of Disposition 1X Burial 2 □Cremation 3 □Remov	20b. F	Place of Dispos		,		20c. Location - City or T	
Ē	Pag ment ant: I		4 Donation 5 Other (Specify)		cklan	d Cemet	ery 4/1:	2/07	Rockland,	VA.
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service Licensee David L. Maelle	C. H. # more	13/	Name and Addre	Mac		uneral Hor Royal,VA	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	is that caused the deat use on each line.	h. Do not ente	r the mode of dyin	ng, such as cardiac c	or respiratory arr	est,	Approximate Interval Between
1966	Physician		Immediate Cause (Final disease or condition resulting in death)		6E (ARDIOI	MYOPAT	thy		Onset and Death 4/2
	/Medical Examiner		F	Due to (or as a conseq		bstruci	tive Pu	lmana	vis Disease	UM
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq			, , , , ,	77101-7	7	113
	ecutec ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	yper te	105/0.	n/				415
60,	icate be executed physician and s the burial-transit		Last Last	Due to (or as a conceq	Luence of):	· Ilat	TAND			LIK
68760,	icate physi s the b	dical	d. //	11/19/	710/	11un				413
.O. Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	yes, outcome pf pregna □Live birth 2 □ Feta □Pregnant at time of c □Unknown	al death 3□	Ectopic pregnancy Other (specify)	/		23d. Date of deliv Month	ery Day Year
Ω.	s that ined by	by Ph	Part II. Other significant conditions contribut	ing to death but not res	ulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use contribute to t	the cause of death?
Records,	w require been sig should b	ed b	Immobility Sy	Mallome	200	ment	Ta	1 🗆 Y	es 2 No 3 Pro	bably 4 Unknown
မင္ပင	law re as be 2 sho	Completed	Diabetes, Frost	tote it	4001	roph	7	24a. Was a		opsy findings available ompletion of cause of
<u> </u>		Com	Failure to the	ve Ai	stre	Steve	CC	perform	med? death? 2 Man 1 ☐ Yes	2 No
Vital	Physician: The lav rthis certificate has ral director, page 2.s	Be	25. Was case referred to medical examiner?			0.11	26. Place of Death			
		٦.	1 ☐ Yes 2 No Hospit 27. Manner of Death 28	a. Date of Injury	ER/Outpatient 28b. Time of	3 □ DOA Oth	4 Nursing Hor		ence 6 Other (Speci	fy)
O	ding Phy h. : After thi funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	28a. Describe no	ow injury occurred	
Division or	Atten r deat ector by the	ifica	2 Puiside 6 Could not be	e. Place of injury - At he	ome, farm, stre				reet and Number or Run	al Route Number,
á	tal or s afte al Dir	Certification:	4 Hornicide	building, etc. (Specif	(Y)			City or Towi	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier (Check only one) 1	: To the best of my kno on the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tir estigation, in my c	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and manner as s late and place, and due t	stated. to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	illes	MO	29c. Licens	e number 5 4 7 4	9 7	9d Date signed (Month,	·
21	H-4		30. Name and address of person who complete	ed cause of death (Item	n 23a) (Type, P	rint) se Ac	e, D-1.	FRED	erick, M	2007
	Sta Registr		31. Date filed (Month APR 1 1 2007	32. Registrar's Signa	b. A	rede				

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Albert James Boothe APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex **Funeral** 2 /105th/ 139.56ar) Months 540-51-0584 1 XM 2 ☐ F 5 Ĭ Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 28a-f show a or 28a-f show the notified at MD Charles Waldorf Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 3273 Westdale Court United States items 23a Examiner must Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or I any injury or other traumatic event, the Medical Examin Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Counselor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Wizeman Jay Daniel Boothe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)
Apt 1908
10101 Grosvenor Place Rockville MD 20852 Alice Boothe - mother Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Lebanon Cemetery 20a. Method of Disposition 1 █ Burial 2 □Cremation 3 □Removal from State Date 20c. Location - City or Town, State 4/11/07 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundamental Service Lin 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardio > Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine ending physician and use as the burial-tran Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 Olæsit Completed peen 24a. Was an page 2 s has autopsy perform funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes this

23e. Did tobacco use contribute to the cause of death?

Month

4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

> 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

3. Time of Death

9. Birthplace (State or Foreign County) Traco

White

Approximate Interval Between Onset and Death

Year

10d. Inside City Limits

1 XYes 2 ☐ No

<u>5:40</u>₽[™]

Voor

Black, White, etc.

2007

2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28h Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

27. Manner of Death
Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

4 ☐ Homicide

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATYAL.MD 11350 PEMBROOK SUITE 304 WALDORF MD 20603

29c. License number

10061652

State Registrar 31. Date filed (Month, Day, Year) 0 9 2007



▼To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

To the Hospital within 24 hours at To the Funeral C

Certification:

Medical

29a. Certifier

29b. Signature and title

		Ear	Plea										II Copies		_	ible.		
		1 - State Registrar									Death			Reg.	12 1	107	1291	ιŊ
Physici	an	Decedent's Name	e (First, Middl	e, Last)									2. Date of D Month		Day	Year	3. Time of Deat	h
/Medic		Dorothy 4a. Facility Name (/	G.		tiani	r)		41	h City T	Town or	Location	of Death	April 5	_	007 4c. Count	v of Doa	10:37 p	IVI
Examin	ier	5514 Ames			and nambe	')		1	-			or Death						
Funeral		5. Social Security N		6. Sex		Age (In yrs.	last birth		f Under fonths	OCKV: 1 Year Days	If Under Hours	24 Hrs.	8. Date of B (Month, D	irth			thplace (State or For	e <i>ign</i>
Director		363-34-10		1□M 2	L X ⊢	73	Y	rs.	TOTALIS	Days	riours	141111.	Sept. 29			Mic	chigan	
land ow t		Usual Residence of 10a. State	10b. County			10c. Ci	ty, Town	or Locati	ion								10d. Inside City Lin	nits
Mary Fied a	tor	Maryland	Mont	comery		D.	ا تسامه	17.									1 □ Yes 2 🔀	No
with the Marylan a or 28a-f show be notified at	Director	10e. Street and Nur	mber	0 1		N(ockvil		10f. Zip	Code				10g.	Citizen of	What Co	ountry?	
death wins 23a must b	ral	5514 Ames	field &						208						USA			
items items ner mu	Funeral	11. Marital Status 1	ind 21 Mar	Ar	as Deceden med Forces ∐Yes 2Ē	?	J.S.	13. Was	s Decede es, speci	ent of Hi ify Cuba	spanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	lo-		ce - Ame ack, Whit	erican Indian, e, etc.	
urs af al', or xami	þ	3 ☐ Widowed		lf 3	res, Give ar or Dates			1 🗆	Yes 2	K No	Specify				Speci	White	:	
72 ho 'natur dical	Completed	(Spec	15. Deceder	t's Education	oleted)			Decedent			ation luring mos	st of work	ina	16b	. Kind of E	Business	/Industry	
within ene.	idu	Elementary/Seco			llege (1-40) 5+	5+)	1	life. DO patio	NOT use	e retired,) -		9		G.		.t. m	
filed v Hygie other 1		17. Father's Name	(First, Middle,	Last)	J-1		accu	фаст	JI Id.I			er's Nam	e (First, Middle	e. Maio			ic Therapy	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the M-dical Examiner must be notified at	To Be	Julius A	. Gietze	en							Emm	a Bra	un			ĺ		
2 shorand Nama is ma		19a. Informant's Na	ame/Relations	hip (Type. Pr	int)		19b. ľ	Mailing A	Address ((Street a	ind Numb	er or Rui	al Route Num	ber, Ci	ty or Town	, State,	Zip Code)	
l and lealth m 27 her tr		Carl A. Ba		lusband		Took I					burt,		ville, M					
ages 1 nt of 1- : If ite		20a. Method of Disp 1 🖾 Burial 2	☐ Cremation		al from State	,	Place of E cemetery,	cremate	on (Namory or oti	e or her place	e)	April	Date 10,	20c	. Location	- City or	Town, State	
artme artme ortant Injury		4 ☐ Donation 21. Signature of Fu			<u> </u>	Gat	e of	Heave	en Cer	neter Addres	y :	20		Sil	ver S	oring	, Maryland	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once.			nohei	25/	ole			1					eral Hom . Silver			MD 30	001	
inat		23a. Part1. Enter the shock, or hea	he disease, or	complication	s that cause se on each	ed the deat	th. Do no	t enter ti	he mode	of dying	g, such as	cardiac	or respiratory	arrest,	ilg.) 20	Approximate Interval Between	
Physician		Immediate Cause (Final		1e:tasta												Onset and Death 9 Months	
/Medical Examiner		resulting in death)			Due to (or a	s a consec	uence of):										
re .	er	Sequentially list con if any, leading to im cause. Enter Unde	nditions, nmediate	b	Due to (or a	s a conseq	uence of):										
executed an and rial-transit	Examiner	Cause (Disease or that initiated events	injury 🦠	S c														
e exe sian ar urial-t		resulting in death) L	_ast		Due to (or a	s a consec	uence of):				-						
The law requires that the death certificate be tee has been signed by the attending physicia bage 2 should be detached for use as the but	Physician/Medica			d														
certifi nding se as	/Me	IF FEMALE: 23b. Was decedent	t prognant	23c. If y	es, outcom	e pf pregn	ancy								234 D	ate of de	liven	-
death e attel	iciai	in the past 12	months?	4[Live birth Pregnant				topic pre ther <i>(spe</i>							onth	Day Year	
at the de by the a stached	hys	9 ☐ Unknown			Unknown													
signed d be det	þ	Part II. Other signif	_		ng to death	but not res	ulting in t	he under	rlying ca	use give	n in Part I						the cause of death?	
w requir been si should	Completed	Recent Bowe	el Ubstr	uction_											2 No	3 🗌 Pi	robably 4XIUnkno	wn
has been seed as a gent as been as a gent as a	mple													s an opsy formed			utopsy findings availa completion of cause (
		25. Was case refer	red to medica								00 Di	-(D - 1	1∐ Yes	2 🔀		1 ☐ Yes	2□No	
Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 🔀		Hospita	l: 1	ient 2] ER/Outp	atient 3	3 DOA	Othe	r-		h <i>(Ch</i> eck o <i>nly</i> me 5 ☑ Res		e 6 □Otl	her (Spe	cify)	
ding Ph T. After th funeral		27. Manner of Death	h 5 ∐ Pendin		. Date of In		28b. Tir Inje		28	c. Injury Work			28d. Describe					
or Attending after death. Director: After in by the funer	catic	2 ☐ Accident 3 ☐ Suicide	investig	gation					М	1 🗆 Y	'es 2 □							
or Attendation differ death Director:	Certification:	4 ☐ Homicide	determ		. Place of ir building, e	ijury - At he etc. <i>(Specii</i>	ome, tarm fy)	n, street,	factory,	office			28f. Location City or To			ber or Ri	ural Route Number,	
To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director; After this certific completely filled in by the funeral director,		29a. Certifier	1 X Certifyir	ıg Physician:	To the bes	t of my kno	owledge,	death oc	curred a	t the tim	ie, date ai	nd place,	and due to the	e cause	e(s) and m	anner as	s stated.	
To the Hos within 24 ho To the Fun completely	edical	(Check only one)	2 ☐ Medical	Examiner: O	n the basis id manner s	of examina	ation and/	or invest	tigation,	in my op	oinion, de	ath occur	red at the time	, date	and place	, and due	e to the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and	title of certifie	~	me	ca	1	nis			number	1 1 1			_		h, Day, Year)	
20		1	w) '							06			*	Pri		6,200	/
		30. Name and address Kelly Mer	ess of person cer, M.I	who complete 9707	d cause of Medica	death (Iten	n 23a) (Ty ter Di	ype, Prin C ive,	^{1t)} #300	, Ro	ckvil	le, M	20850					
Sta	te	31. Date filed (Mont				trar's Signa												
Registra	ar	AP	R 09	2007	State Contraction	الر ما	K A	1004	20									

			4 Chan	epartment of Health and M	lental Hygie	ene 2007 1201.1
			Registrar Amend # 10e & 19b per FH/PH	esenducate 200 path CNN	M Reg. 2. Date of Death	No. 3. Time of Death
	Physici /Media		Preston Elliott Best		Month April 06	Day Year
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Golden Living Nursing Home	Frederick		Frederick
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs. last birth 87 Yr.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Jan. 20,	9. Birthplace (State or Foreign County) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. tnside City Limits
	Mary a-f sh	to	Maryland Frederick Freder	cick		1⊠Yes 2□No
	th the or 284 e rot	Directo	10e. Street and Number 15 MT. Olivet Blvd.	10f. Zip Code	10g	. Citizen of What Country?
	ath w		15 Mount Olive Blvd.	21701	U	Jnited States
36	ges 1 and 2 should be flied within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, It is Madical Exercipational to notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No. If Yes, Give WWII Year or Dates:	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☒ No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	n 72 hou "natural	Completed t	15. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of workir de. DO NOT use retired)	ng 161	b. Kind of Business/Industry
212	d withi	omp	Elementary/Secondary (0-12) College (1-4or 5+)	cvice Foreman		Telecommunications
힏	al Hygie I other vent, II	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	
Ya	should ba filed and Mental Hyg s markad othe umatic event,	Lo	John T. Best	Hester Ha	aller	
ā	d 2 sh th and th and traum			Mailing Address (Street and Number or Rural MT. Olivet Blvd.		
	s 1 an f Heal item 2 other		20a. Method of Disposition 20b. Place of Disposition	isposition (Name of crematory or other place) April		C. Location - City or Town, State
<u>E</u>	Page nent o ant: If ury or		Donal S Donalistical D Danioval italii State	ven Crematory 200	_	ederick, Maryland
Baltimore,	parmit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra ance.		21. Signature of Foreign Service Licensee	22. Name and Address of Facility Resthaven Funeral Se	ervices,	Skkot Cody P.A.
	-		23a. Part. Entir the disease, or implications that caused the death. Do no shock, or heart failure / Lir only one cause on each line.	9501 Catoctin Mtn. I tenter the mode of dying, such as cardiac or	HWy . ドアのd r respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final FAILURE	TO THRIVE		Onset and Death
	/Medical Examiner		Due to (or as a consequence of REVAL	FAILURE		
		er	Sequentially list conditions, b. Due to (or as a consequence of		34-1	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	avy Embo	li	
20,	certificate be executed Iding physician and Ise as the burial-transit		resulting in death) Last Due to (or as a consequence of)		<u> </u>	
09/89	physicate to physical	dical	d			
Box	eath certific attending p	In/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	205		23d. Date of delivery
o.	0 0	Physiclan/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
S,	res that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w require been sig should b	eted			1 🗆 Yes	2 No 3 Probably 4 Unknown
I Kecords,	a la has	Comple			24a. Was an autopsy performed	
VItal	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
ō	Phys	- To	1		ne 5 Residence	e 6 Other (Specify)
0	nding f tth. :: After e funer	atlon	1 DNatural 5 Pending (Month, Day Year) Inju		.ou. Describe flow i	njury occurred
UIVISION	l or Attending after death. Director: After I in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 2	8f. Location (Stree City or Town, St	t and Number or Rural Route Number,
5	spitel or A ours after neral Direc filled in by	O				
	To the Hospitel or within 24 hours af To the Funeral Di completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, c 2 Medical Examiner: On the basis of examination and/c and manner stated.	eath occurred at the time, date and place, ar r investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
/	MIL)/WW/	D 047951	9	-06- 2007
5) X / 1.		30. Name and address of person who completed cause of death (Item 23a) (Ty BRE A KAZMI TIN 814	Tou House Ave	e theo	ERICK, HD 21701
	Sta Registra		APR 1 0 2007 32. Figistrar's Signature	Speeds		-06- 2007 PERICK, HD 21701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Dona1d Glenn Bartoo 06, 2007 11:05 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5911 Bryn Mawr Road College Park

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Prince Georges 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**M** 2□ F Months 220-05-0311 Director 12/06/1911 Mercer, Usual Residence of Decedent with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-f shov other treumatic event, the Modical Examiner must be notified at 1¥ Yes 2 ☐ No Director MD Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 5911 Bryn Mawr Road death v 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: à 3 Widowed 4 Divorced Year or Dates: **Navy** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7; and Mental Hygiene 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Alton Bartoo Helen Lytle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n eny injury or other treum Anita M. Bartoo / Wife 5911 Bryn Mawr Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory Brentwood, MD 4/9/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ft. Lincoln Funeral Home, Inc. 23a. Part. Exter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road, Brentwood, MD 20722 Approximate Interval Between Several years Immediate Cause (Final Priysician disease or condition resulting in death) chronic rena /Medical Due to (or as a consequence of): **Examiner** hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by serile dementic 1 ☐ Yes 2 🕍 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital 1 Yes To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending To the nosperation of the Funeral Director: Africal or the Funeral Director: Africal in by the fu investigation м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and MIe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 022780 ass of Krson who completed cause of death (Item 23a) (Type, Print) Schissler MD 7500 Greenway Ctr Dr. Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	arylan		artmen rtificat			and M	Re	g. No.	007	12943
н	Physici	an	Decedent's Name (First, Middle, La	,							Date of Death Month	Day	Yeer	3. Time of Death
100	/Medi		PINKNEY HERBER								April	3	2007	7:55 P M
	Examir	ner	4a. Facility Name (If not institution, give	,			, , ,		Location of	f Death			ounty of Deatl	
27	· /// · · · · · · · · · · · · · · · · ·	*	CLINTON NURSING					LINT	ON If Under 2	14 Uso		PR	INCE GE	
	Funeral	9.1	5. Social Security Number 6. S	iox 7. Age	83	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day,		9. Birth	nplace (State or Foreign untry)
	Director	χ.	217-34-2363 Usual Residence of Decedent		-05						Sept 13	192	23 Suit	land MD
	ow ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Man Man	to	Maryland Prince (George's	C1i	inton								1x Yes 2 □ No
	r 28e	Director	10e. Street and Number				10f. Zip	Code			10	g. Citize	n of What Co	untry?
	73a o	O E	9211 Stuart Lane				20	0735				Unit	ed Sta	tes
	deat ms	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.	S. 13. V			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		. Race - Amer	ncan Indian,
စ္	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖾 N If Yes, Give	lo		1 Tes, spec 1 □ Yes			, Puerto	Hican, etc.)		Black, White	_
g	iral',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:			10 105	2 X) 140	Specify:			5	Specify: B1	ack
5	within 72 hours after death with the Maryland ene. than 'natural', or Items 23s or 28e-f ehow ha M. dical Exartifier must be notilised at	Completed	15. Decedent's E (Specify only highest gra			16a. Deced (Give	dent's Usua kind of wo	al Occupa rk done d	ation <i>Juring m</i> ost)	of worki	ng 1	6b. Kind	d of Business/I	ndustry
2	han han	m d	Elementary/Secondary (0-12)	Coflege (1-4or 5	+)		ро моти: stal					0		
N T	dygie ther t	ပိ	12 17. Father's Name (First, Middle, Last	1		10	Stal			da Nassa	/Fine Adielella Ad		vernmen	nt
and	d of o	Be	David T. Brooks								(First, Middle, M		umame)	
Ĕ	d Me d Me mark matic	2	19a. Informant's Name/Relationship (405 44 35		/0:			t Carro			
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f ehow with figury or other treumatic event, the Macical Extrating must be notified at anone.	K 4	Kevin Brooks/So								I Route Number,			
Baltimore, Maryland 21215-0036	1 an Heal em 2		20a. Method of Disposition	11	20b. P	lace of Dispo	DOSW sition (Nan	ell ne of	Ртасе	, Up	per Mari	bor	o Mary] ation - City or 1	Land 20772
Ö	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐			lace of Dispo- emetery, cren			1				-	
=	artme ortan njury		4 Dogation 5 Other (Special 21. Signature of Fuderal 5 Wis Light		FOI	rt Line	COIN	Ceme	tery	4/1	0/07 B	reni	twood,	Maryland
Ba	Depre lmp			XII		5.5	. Name an	ar1h	oro D	Pop	e Funera	1 H	omes, F	1.A. 1and 20747
	W. 184		23a Part 1 Enter the disease or com	plications that caused	the death								e, Mary	Approximate
H			23a. Farti Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	θ.	. Do not ont	51 1110 11100	o or dying	g, 30011 a3 c	Jai diac o	i respiratory arres	οι,	F	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Pneumon										
	Examiner			Due to (or as a	a consequ	uence of):								
		-er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	uence of):								
	uted I ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•		,								
,	exect n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequ	uence of):								
8760	icate be executed physician and s the burial-transit	dicail		d										
89	ificati g phy as the	edic		. 0.										
Box	eath certific attending pl for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of								23	d. Date of deli	/erv
ň	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pr Other (sp						Month	Day Year
J.	at the de by the a tached	hys	9 □ Unknown	9□ Unknown										
ري ح	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as t	ру Р	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the un	nderlying ca	ause give	n in Part I.		23e. Did toba	icco use	contribute to	the cause of death?
ğ	w require been sig should b	pa	Chronic Renal D	isease							1 ☐ Yes	2 🗆	No 3□Pro	bably 45 Unknown
Vital Records,	s bee	Completed	Hypotension								24a. Was an		24b. Were aut	opsy findings available
ř	The lav	E	Dractate Concer								autopsy	ed?	prior to co death?	ompletion of cause of
		0	Prostate Cancer 25. Was case reterred to medical						26 Place	of Death	1 Yes 2	-	1 ∐ Yes	2 No
≥	Physician: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	nt 2 🗆 I	ER/Outpatient	t 3 DO	Othe			ne 5 ☐ Residen		Other (Spec	(64)
			27. Manner of Death	28a. Date of Injun (Month, Day		28b. Time of		8c. Injury Work	at		28d. Describe hov			119)
0	Attending In death.	atio	1 Accident 5 Pending 2 Accident investigation	1	rear)	Injury	М		′ ′es 2 □ N	io				
DIVISION	recto	5	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju- building, etc.	ry - At ho	me, farm, stre	et, factory	, office		2	28f. Location (Stre	et and	Number or Rui	ral Route Number,
5	0 # 5 5	Certification;									City or Town,			
	Hospital 24 hours a Funeral tely filled	1	29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knov	wledge, death	occurred	at the time	e, date and	place, a	and due to the cau	ıse(s) aı	nd manner as	stated.
	To the Hosp within 24 hos To the Fune completely fi	edical	one)	piner: On the basis of and manner stat	examinat	ion and/or inv	estigation,	in my op	inion, deatr	OCCUFFE	o at the time, dat	e and p	ace, and due	to the cause(s)
	2 1 8	Σ	29b. Signature and title of certifier	to	11.	1	1	. License					signed (Month	
	(15)		1 Daly	Jorde	W	M	ML	504	154			Apri	116,2	007
	000		30. Name and address of person who	completed cause of de	ath (Item	23а) (Туре, Р	Print)	, , .	2 / 1		: 1 C	. d	. Мо	land 20002
	200		Arastoo Yazdani M				ue, S	uite	3-41	L, S:	iiver Sp	r Tug	, mary	Talla 20902
F9 3	Sta Registr		APR 1 U 2007	32. Registra	r's Signat	ture								

For Phys /Me Exar **Funer** Direct permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Constance A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution, see and and number) A Partilly Name of an institution of Death of the Name of See and number of See and Name of See and	1	State Registrar		Cer	tificate of	Death	F	Reg. No.	07	12944
Constance Ann Barton Apr 10, 2007 Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth Anne Arundel Security Number 4. County of beth 4. County		1. Decedent's Name (First, Middle	e, Last)				Month	Day	Voor	3. Time of Death
As Facility Parts (Prior Actunoide) See Deed and number) Not Actunoide Rehab Social Social Social Social Parts (Prior Actunoide) 10 Social Social Social Parts (Prior Actunoide) 10 Social Social Social Parts (Prior Actunoide) 10 Social Social Social Parts (Prior Actunoide) 10 Social Social Parts (Prior Actunoide) 10 Social Social Social Parts (Prior Actunoide) 10 Social Social Parts (Prior Actunoide) 11 Social Parts (Prior Actunoide) 12 Social Parts (Prior Actunoide) 12 Social Parts (Prior Actunoide) 13 Social Social Parts (Prior Actunoide) 14 Social Parts (Prior Actunoide) 15 Social Parts (Prior Actunoide) 16 Social Parts (Prior Actunoide) 17 Social Parts (Prior Actunoide) 18 Social Parts (Prior Actunoide) 19 Social Parts (Prior Actunoide) 19 Social Parts (Prior Actunoide) 10 Social Parts (Prior Actunoide) 10 Social Parts (Prior Actunoide) 10 Social Parts (Prior Actunoide) 11 Social Parts (Prior Actunoide) 12 Social Parts (Prior Actunoide) 13 Social Parts (Constance	Ann	Barton			Apr 10), 2007	1	2:35 am ^м
21.4—16—2.5.27 Image: Part Part	er 4	North Arundel	Rehab		Glen Bu	ırnie		Anne		lel
10.5 Bales 10.5 December		214-16-2527	404 005				Jul 22,	1916	9. Birthpla Countr	ce (State or Foreig
MD Anne Arunde Baltimore Highlands 1.09. Street and Number 2.106.1 U.S.A			10c.	City, Town or Loc	cation				100	d. Inside City Limits
11. Martin Status 12. Was Depodent Ever in U.S. 13. Was Depodent of Hispatic Origin? (Specify Yes or No. II. Race - American Int. II. Martin Status 13. Was Depodent of Hispatic Origin? (Specify Yes or No. II. Race - American Int. II. Was Depodent of Hispatic Origin? (Specify Yes or No. II. Race - American Int. III. Race		MD Ann			nore High	lands				1 □Yes 火 □ No
West Color Specify S	ral Dire					21061		•		<i>y</i> ?
16. Decedent's Education (Spacify and yinghest grade completed) 16. Decedent's Usual Occupation (Spacify and yinghest grade completed) 16. Decedent's Usual Occupation (Sine bit of previous data during most of working (Sine bit of previous data data during the previous of the previous data data data data data data data dat		1 ☐ Never Married 2 ☐ Marr	If Yes, Give	13. V.S. 13. V			pecify Yes or No- o Rican, etc.)		ck, White, et	c.
19b Mailing Address (Street and Number or Run) Flave Murber or Run Flave Murber or Sund	leted	(Specify only highes	st grade completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wor	king	16b. Kind of B	usiness/Indu	stry
Sandy Stevens 1969 Management 1969 M	E	Elementary/Secondary (0-12)	College (1-4or 5+)			7		MVA		
19b. Nating Address (Sizere and Number of Plaus Route Number, City or Town, State, 280 Card Sandy Stevens 280 Flace of Disposition (Name of Contracting Centrality) (Stevens) 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method of Disposition 1 201 Method			Last)				. , ,	Maiden Surnar	ne)	
Carpelli Fundarial Notes Carpelli Fundarial		19a. Informant's Name/Relationsl Sandy Stevens	hip (Type. Print) daughte	er 280	g Address (Street 7 Louisiar	and Number or Ru na Avenue	ural Route Numbe B Halet	er, City or Town, thorpe	State, Zip C	² 1227
21. Signature of Fineral Safeta Leonsee 22. Name and Address of Facility FredLock Funeral Home 31. Jones Street, Piedmont, WV 26750 23a. Part I. Enter the disease, or complications that caused fibring the properties of the pr	2	1 Burial 2 X Cremation	3 □Removal from State	cemetery, cren	natory or other plac	P.A.		_		n, State
23a. Part I. Enter the disease, or complications that caused fire Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death Do not enter the mode of dying such as cardiac or respiratory arrest, interesting in death Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the mode of plant Do not enter the										
Temporaries Temporaries	-	23a Part1 Enter the disease or	complications that caused the	-111						Approximate
28b. Was decedent progrant in the past 1g profiths?	Examiner	disease or condition resulting in death) Sequentially list conditions, I any include the conditions, I any included the conditions of the	bDue to for as a cons	se tuence of):	mytan	((2)				
25. Was case referred to medical examiner? Comparison		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 🗆		,				
25. Was case referred to medical examiner?	<u>ک</u> ا				derlying cause giv	en in Park	14/1			
25. Was case referred to medical examiner? Second Se	omplete						autop perfo	rmed?	prior to comp death?	pletion of cause of
Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:						26. Place of Dea				
27. Manner of Death 1 Matural 2 Accident 3 Sulcide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	0		Hospital: 1 ☐ Inpatient 2	ER/Outpatient	t 3□ DOA Oth	er: Nursing H	ome 5 ☐ Resid	dence 6 🗆 Oth	ner (Specify)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of entifier 29c. License number 29c. License number 29d. Date signed (Month, Day, A - 10 - 07)		1 Natural 5 Pending investig	g (Month, Day Year gation				28d. Describe h	now injury occur	red	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title prefitier 29c. License number 29c. License number 29d. Date signed (Month, Day, A - 10 - 07)	Certific		ined 286. Place of Injury " A		eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	ber or Rural I	Route Number,
D57028 4-10.07		(Check only 2 Medical	Examiner: On the basis of exam							
	Me	29b. Signature and title of Certifier			29c. Licens	57028		29d. Date signe	d (Month, Da	ay, Year)
5 30 Name and address of person who completed cause of death (Item 33a) (Type, Print) Aug. #231 Anna polls MD 214	5	Name and address of person	who completed cause of death (I	tem 23a) (Type, F	Print) Allo -	1-221 A	inna pr	dis M	D 21	401

State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

APR 12

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			For State Registrar	State of Ma		artment of Healt <i>rtificate of Dea</i>		Hygiene Reg. No. 2	7 12945
	Physici	an	Decedent's Name (First, Middle, Last) CENTAR			DIATE	2. Date of Month	Day Y	3. Time of Death
	/Medio		STUAR 4a. Facility Name (If not institution, give			BLAIR 4b. City, Town, or Locat	tion of Death	08 200 4c. County of	1039
			WMHS-BRADDO		l	CUMBERLANI	D	ALLEGA	
	Funeral			x 7. Age M 2□F	e (In yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date of urs Min. (Month,	Birth 9 Day, Year)	Birthplace (State or Foreign Country)
lant .	Director		Usual Residence of Decedent		73		Jan	uary 23, 1934	Maryland
	aryland show d at	_	10a. State 10b. County		10c. City, Town or Lo	eation			10d. Inside City Limits
	the Ma 28a-f	Director	Maryland Alle	egany		Lor 10f. Zip Code	naconing	10-035	1 A Yes 2 No
	3a or	i D		11			11523	10g. Citizen of Wha	
	death	Funeral	11. Marital Status	llegany Street 12. Was Decedent 8 Armed Forces?		Was Decedent of Hispanio If Yes, specify Cuban, Me	21539 c Origin? (Specify Yes or	No- 14. Race -	U.S.A. American Indian, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 🗷 Yes 2 ☐ N If Yes, Give Year or Dates:	No.	/	ecify:	Specify:	
5-0	72 hc "natur dical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kind of Busin	White ness/Industry
121	within ene. than '	ldmc	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	,			
19	e filed al Hygi other /ent, t	Be C	17. Father's Name (<i>First, Middle, Last</i>)	0			Technician Mother's Name <i>(First, Mia</i>		Paper Mill
ylar	Ments Ments arked atic ev	To E		John Blair				Virginia Walbe	rt
Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Ty	·	19b. Mailii	ng Address (Street and No			
ē,	is 1 and 2 of Health a item 27 Is other trat		Shirley Ann B		20b. Place of Dispo	sition (Name of	gany Street, Lona	coning, Maryla	
E O	Pages nent of nt: If i		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		^{matory} or other place) urg Memorial Par	April 12		ourg, Maryland
Baltimore, Maryland	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	060-	2:	2. Name and Address of F Eio	acility chhorn-McKenzi	e Funeral Home	PA
	* *		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death. Do not ent	er the mode of dying, suc	Main Street, Long	aconing, Maryla	and 21520
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each lin	ie. Na klaw	anstrisie	,	,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	1001 ADIZ			I MOUR
	Lxammer	-	Sequentially list conditions,	Due to (or as a	a consequence of):	Ardial I	nfarcti	on	-36 Hours
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
, 0	e exec fan an urial-tr		resulting in death) Last	Due to (or as a	a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical		d					
Box 6	leath certifi attending I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome				23d. Date o	of delivery
O. B	Physician: The law requires that the death cer this certificate has been signed by the attendiral director, page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
, P.O.	that the	V Ph	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	nderlying cause given in P	Part I. 23e. D	id tobacco use contribu	ute to the cause of death?
rds	equires en sign ould be	ed by	Diabetes, Ch	ronic	Renal in	ISUFFICIE	ency 1	□Yes 2□No 3[☐ Probably 4 ☑ Unknown
Vital Records,	e law re has be	Completed	Recurrent he	RACI AN	d Neck	CANCER		utopsy prio	re autopsy findings available or to completion of cause of
a	n: Th ficate or, pag		OF Mos case referred to modical				1□ Ý€		ith? Yes 2 ⊠ No
₹	ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ⊠Inpatie	nt 2 ☐ ER/Outpatier	Othor	Place of Death Check on Nursing Home 5□ R		(Specify)
Division or	ding Ph J. After th funeral	on: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o			be how injury occurred	Ореспу
Sio	or Attendi after death. Director: # in by the fi	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of inju	ıry - At home, farm, str	M 1 ☐ Yes :		n (Street and Number o	or Purol Pauta Number
<u>></u>	tal or A s after al Dire ed in by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)			Town, State)	or narar noute warmber,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	edical (29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/or in	n occurred at the time, dat vestigation, in my opinion,	te and place, and due to , death occurred at the tir	the cause(s) and manner me, date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 i. A	NO	29c. License numb	ber	29d. Date signed (A	
			> Hrma Slea	W .	M D	D4634	16	41910	7
	a VA	a	30. Name and address of person who co	impleted cause of de	eath (Item 23a) (Type,	Print)	perland, n	nh DIEAC)
	Sta	te	31. Date filed (Month, Day, Year)		O NEIH TI ar's Signature	ve . Cuno	a juici, 11	IU XIDUA	£ .
	Registr	_	APR 11 2	2007	was Ar L	Anada.			

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 Physician APRIL 3 Helen L. Bazzel 4:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Yea Time 13, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 6. Sex 3^{Year)}1911 9. Birthplace (State or Foreign Days Hours 1 □ M 28734 95 181-01-4294 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Charles Maryland LaPlata 1 ☐ Yes 20 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1024 Wiltshire Drive 20646 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes **2€X**No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: 3℃Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: if item 27 is marked oil any injury or other traumatic ever ones. Be Cleveland Yowell Mary Bonner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Kerby/daughter 1024 Wiltshire Drive LaPlata, Maryland 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 4/5/2007 Baltimore, Maryland 5 Other (Specify) 4 □ Donation Funeral 1 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pheumm disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D- 52289 /2007

Registrar

State

3

LANE SUITE 107 WALDORF, MD 20601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NALIN MATHUR 11855 HOLLY

31. Date filed (Month, Day, Yea

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Certi	ificate of Death	Reg. N		
			Decedent's Name (First, Middle,	ist)	N/	2. Date of Death	ay Year	3. Time of Death
	Physici /Medio		Gladus	I. KING	BIVENS	04 10		1100 AM
7	Examin		4a. Facility Name (If not institution,	re street and number)	4b. City, Town, or Location of Death	1 4	c. County of Death	,
		Н	28720 Hudso	OFNER Road	If Under 1 Year If Under 24 Hrs.	9. Date of Bigh	oners	
	Funeral Director		5. Social Security Number 219-14-3212 Usual Residence of Decedent		Months Days Hours Min.	8. Date of Birth (Month, Day, Year 2 - 9 2	9. Birthpi Coun	lece (State or Foreign try) Nd
	/land		10a. State 10b. County	10c. City, Town or Loca	tion	-	10	Od. Inside City Limits
	Man B-f sh	ctor	mol Some	rset Marion				1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Mudical Examiner must be notillised at	Funeral Director	10e. Street and Number 28720 Huc	SON COFNET Road	10f. Zip Code 2/838		itizen of What Coun	4-
	er dez Itams ner m	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	as Decedent of Hispanic Origin? (S res, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
215-0036	hours after	by	1 Never Married 2 Married 3 D(Widowed 4 Divorced	Year or Dates:	Yes 20 No Specify:		Specify: Blo	ick
15	in 72	Completed	15. Decedent's (Specify only highest	rade completed) (Give kir	nt's Usual Occupation nd of work done during most of wor DNOT use retired)	king	Kind of Business/Inc	ustry
212	with jene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Crabs	Sei	afond I	nd.
	e filed al Hygid other vent.	Bec	17. Father's Name (First, Middle, La	9	18. Mother's Nan	ne (First, Middle, Maide	n Sumame)	
Maryland	should be filed with nd Mental Hygiene i marked other thai urnatic event, the	To	George Edu	ard King	Sara	h Cott	man	
Jar	2 sho		19a. Informant' / ame/Relationship	Type, Print) 19b. Mailing	Address (Street and Number or Ru	0 .		Code)
	1 and 3 Health tem 27 other tr		20a, Method of Disposition	20b. Place of Dispositi	William Koad	Date 20c. I	ocation - City or To	wn. State
Baltimore,	8 = 5		1, Burial 2 Cremation 3 4 Donation 5 Other (Spe		tory or other place)) (10 T		· · · · · · · · · · · · · · · · · · ·
	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Lig	10 0 10 10 10 10	Name and Address of Facility Re	-NIO Smi	MPOFUNCE	EL HOR
B	permit. Departi Import. any inj		Di.M X	Feet P. C	1. Box 331 Po	comoke	City, m	1.21851
	100		23a. Part1. Enter the disease, or construction shock, or heart failure. List on	replications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	//	Approximate Interval Between
	Physician	į li	Immediate Cause (Final disease or condition	ADVANCED ALZ	HEIMER'S DE	MENTIA		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	LAUIIIIII	10	Sequentially list conditions,	b. Due to (or as a consequence of).				
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Date to (or as a seriocyastice of).				
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	C. Due to (or as a consequence of):				
68760	icate be executed physicien and s the burial-transit	cal		d				
_	ntifica ng ph s as th	Medical	IF FEMALE:					
.O. Box	The law requires that the death certificate be executed are has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown		ctopic pregnancy hther (specify)		23d. Date of deliver Month	ry Day Year
0_	that the			contributing to death but not resulting in the unde	ertving cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
rds,	w requires been signe should be	ed by				1 ☐ Yes 2	Proba	ably 4 □Unknown
Records,	The law re cate has be page 2 sho	Completed			-	24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Vital		0	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☐ N th (Check only one)	- 12100	222(10
of V	y ≈ y	To B	examiner? 1 ☐ Yes 2 No		3□ DOA Other: 4□ Nursing H	ome 5 Residence	6 ☐Other (Specify)
ם ם			27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how inju	ıry occurred	
<u>s</u> .	Attending or death. ector: After by the fune	cati	2 Accident investigat 3 Suicide 6 Could not		M 1 Yes 2 No	28f. Location (Street a	and Number or Pural	Pouto Number
Division	2 2 2 2	Certification;	4 Homicide determine	28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	City or Town, Stat		noute Number,
_	Hospite 4 hours Funerel tely filled	edical C	29a. Certifier (Check only one) Certifying 12 Medical Ex	hysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	and due to the cause(s	s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of sectifier		29c. License number	29d. D	ate signed (Month, L	Jay, Year)
	- s + ŏ		rolly	M)	D0062172	4	19/2007	
	5 MA		30. Name and address of person wh	completed cause of death (Item 23a) (Type, Pri	int)			
	and a		SHARAD R		MARKET ST P	comole	M1) 2	1851 .
	Sta Registr		31. Date filed (Month Pay, Year)	007 32 Registrar's Signature	S. I			

			For State	State	of Maryla		artment of				_	A 100		1.0	01.0
	10 July 20		Registrar 1. Decedent's Name (First, Middle)	e Last)		Ce	illicate of	Dealli		2. Date of De	Reg. No	20	1/	3 Time o	Doath
	Physici			hin						Month	Da	007	Year	1.20	a _M
	/Medic		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of		April	<u> </u>	County	of Death	1:30	
	LXaiiiii	-	Shady Grove Ad	ventist	Nursina	& Reha	b Rockv	ille				Mont	gome	rv	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da			9. Birthp	lace (State	or Foreign
	Director		579-46-4900	1 □ M 2 🛣 🗶	84	Yrs.	Months Days	Hours		Jan. 2		923	Cour	china	
ğ	>		Usual Residence of Decedent 10a. State 10b. County		100.0	it. Town or la	ontion							0.1.1	
aryla	shov ed at	<u>-</u>	10a. State 10b. County		100.0	ity, Town or Lo	cation						1	0d. Inside C	2 No
he M	28a-f otiffle	Director	Maryland Fr	ederick		Fred	erick			1	10 0				
with 1	a or			·			10f. Zip Code				10g. Cit		hat Cour	itry?	
eath	ns 23 must	Funeral	5003 Saint S		rt ecedent Ever in U	IS 13		703	igin2 (Spec	sify Ves or No		USA 14 Bace		an Indian,	
fter d	iner	표	1 ☐ Never Married 2 ☐ Married	Armed	Forces?	J.G. 10.	Was Decedent of If Yes, specify Cut	an, Mexican	n, Puerto F	Rican, etc.)		Black	, White,	etc.	
UUSO hours af	al", o	by	3√ Widowed 4 Divorced	If Yes, (Year or	Give T		1 □ Yes 2√□ No	Specify:				Specify:	Asi	an	
2 ho	atur Ical E	Completed		t's Education	41		dent's Usual Occu		4 -4		16b. K	ind of Bus	siness/Ind	dustry	
thin 7	e. Med	ed l	(Specify only highe Elementary/Secondary (0-12)	-	(1-4or 5+)	- life.	kind of work done DO NOT use retire	ed) ed)	ii or workin	g					
N be	/gien er th t, the	8	6			R	<u>estauran</u>	t Owne	er			Se	lf E	mploye	d
e ĕ	d oth	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden	Surname	e)		
	Men arke atic e	၉	King Wah Lim			,				i Lee					
2 sh	is m raum		19a. Informant's Name/Relations Mary Lee Chin		n =0		ng Address (Stree							,	
C, F	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	- 35	20a. Method of Disposition	/ Daugne			Saint S								
Ses Ses	1 = 5]		1 ☑ Burial 2 ☐ Cremation		n State	cemetery, crei	matory or other pla		April	i	20c, Lo	cation - t	City or 10	wn, State	
Daltillo	rtmel rtant njury	1 2	4 □ Donation 5 □ Other (S		Geo		shington 2. Name and Addr	-		2007	Ad	elph	i, M	arylan	ıd
perm perm	Depa Impo any l		1 Ken Sule	Licensee		Fr	ancis J. O Univer	Coll	ins F					, MD 2	20901
			23a. Patt. Enter the disease, or shock, or heart failure. List	complications that	t caused the dea									Approximat Interval Bet	te
Ph	ysician		Immediate Cause (Final disease or condition	Deme									1	Onset and	Death
	Medical		resulting in death)	a	o (or as a conse	quence of):									
=)	kaminer		Sequentially list conditions,	b. Stro										1 Ye	ear
pa	sit	inel	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):												
Kecut	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):	-								
The law requires that the death certificate be executed	physician and the burial-transit	<u>е</u> Ш			0 (01 00 0 00100	quonoc oi).									
ficate	phys s the	edical		d											
Certii	been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregr							23d Date	of delive	27/	
death	d for (cial	in the past 12 months?		e birth 2 □ Fet gnant at time of		Ectopic pregnand Other (specify) _	ру				Mon		,	Year
j e	yy the achec	hysi	9 Unknown	9□Uni	nown										
o, r⊓ stha	e det	by P	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I.		23e. Did t	obacco u	se contri	bute to th	ne cause of c	leath?
adnire	en sig	ed t	Hypertension							10	Yes 2	□No	3 ☐ Prob	ably 4 🔀	Jnknown
aw re	2 sho	Completed								24a. Was		24b. W	vere auto	psy findings	available
The	ate ha	mo								autor perfo	rmed? 2 TNo	d d	eath?	npletion of c 2 □ No	ause or
ian:	ertific ctor,	Be (25. Was case referred to medica examiner?					26. Place	of Death	Check onl		'			
hysi	this certificate has al director, page 2	၉	1 ☐ Yes 2X No			ER/Outpatier	I JU DOA		ırsing Hom	ne 5 □ Resid	dence	6 □Othe	r (Specif	y)	
ing P	After 1 unera	ü	27. Manner of Death 1 X Natural 5 ☐ Pendin	g (Mo	e of Injury onth, Day Year)	28b. Time of Injury	Wo			8d. Describe I	how injur	y occurre	ed		
tend	tor: / the f	cati	2 Accident investigns investigns and Suicide 6 Could	not be]Yes 2□I	-						
or A	offer of Direction by	Certification:	4 ☐ Homicide determ	ined 28e. Plac buil	ding, etc. (Spec	ify)	eet, factory, office		2	8f. Location (8 City or Tox	Street an vn, State	d Numbe)	er or Rura	l Route Num	ıber,
spital	ours a		29a. Certifier 1 Kertifyir	ng Physician: To ti	ne best of my kn	owledge, deat	n occurred at the t	ime. date an	nd place, a	nd due to the	cause(s	and mar	nner as si	ated	
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) Medical	Examiner: On the	basis of examin anner stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurre	ed at the time,	date and	place, a	nd due to	the cause (s	\$)
To t	Vithi Comp	Me	29b. Signature and title of certifie	r			29c. Licen	se number			29d. Da	e signed	(Month,	Day, Year)	
			Alles				d286	556				Apri	19,	2007	
)	3		30. Name and address of person					C+1	0 × C=		MD C	0010	١	· · ·	
(a)	- 01		Ravi Passi, M.I		Second Registrar's Sign		#404B,	DT1A6	er pl	r rug,	TIU Z	.0316	,		
	Sta Registr		on Date mod (MRIPA), Par	2007	Alike	H A	and I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day April /Medical Charles 6, 2007 0323 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F Director MAR 9, 1940 67 595-54-8905 Haiti 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits notified ; Director 1 ☐ Yes 2 X No Maryland | Montgomery 28a-f Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 2700 Barker Street 20910 death Haiti 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or ite Black, White, etc. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farm Worker Agriculture permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Charles Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19a. Informant's Name/Relationship (Type. Print) Pierre Emmanuel Charles/Son 1505 Hampshire West Ct., #13 Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Gate of Heaven 4/14/2007 Silver Spring, MD 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD M00956 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrhythmiz disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dilezze COLOUSIN Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examiner physician and the burial-transit Hypertension Due to (or as a consequence of): Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) has been signed by the a e 2 should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? failure Heart Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page death? 1 Yes 2 No 2 No funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 THNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar 31. Date filed (Month, Day, Year) APR 1 0 2007

EBernanno.

Esserman M

8600 Old Geogetown Rd, Bethodo, MD 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D35588

State of Maryland / Department of Health and Mental Hygiene 0 0 7 1 - For State Certificate of Death

			- Hegistrar			00,	imodic or	Douth		neg. No.		1
	Physici	an	1. Decedent's Name (First, Middle, Last Douglass) Carringto	n CO	CHRAN	1		2. Date of Dea Month April 7	Day	O7	3. Time of Death 7:30 a. M.
	/Medic							r Location of Deat			County of Death	
	Examin	er	4a. Facility Name (If not institution, give 12033 Belvedere				Hagers		"	1	ashingt	
					// · · · · · · · · · · · · · · · · · ·	2-10-10-3	If Under 1 Year		O Data of Bird			
	Funeral Director		5. Social Security Number 6. Se 223–26–4322	x 7. Age M 2□F	(In yrs. last b 83	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Nov • 27	, Year) 192	3 Virg	nplace (State or Foreign untry) ginia
			Usual Residence of Decedent									
	land		10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Mary F Bh	jo	Maryland Washingt	on	Hage:	rstov	m					1 ☐ Yes 2X No
	28a	ec	10e, Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?
	with	ā	12033 Belvedere R	coad				1742		I	J.S.A.	
	eath	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13 W			Specify Yes or No		4. Race - Amer	ican Indian.
_	ter d	Ë	1 Never Married 2 Married	Armed Forces?		If	Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	to Rican, etc.)		Black, White	
ž	urs at	ξ	3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give W Year or Dates:	.W.II	1	☐ Yes 2 🖾 No	Specify:			Specify: W	hite
5	ture	ed	15. Decedent's Edu	ucation		a. Deced	ent's Usual Occup	pation		16b. Kin	nd of Business/I	ndustry
2	n 7	ple	(Specify only highest grad		`	(Give F life. D	kind of work done OO NOT use retired	during most of word d)	rking			
7	filed within 72 hours after death with the Maryland Hygiene. other then "neture!", or iteme 23a or 28e-f show ant, the Madical Expandrational be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	,	supe	ervisor			boar	d of ed	ducation
2	Hyg othe	Bec	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			18. Mother's Nar	ne (First, Middle,	Maiden S	Sumame)	
<u>8</u>	Id be enta ked ic ev	To B	Thomas R.	Cochran					Wall	Lace	Low	
	Shou ond N	_	19a. Informant's Name/Relationship (7)	ype, Print)	19	9b. Mailin	g Address (Street	and Number or Ru	ural Route Numbe	er, City or	Town, State, Z	îp Code)
Ĕ	od 2 Itha 27 is		Eleanor Cochran -	wife	1:	2033	Belvede:	re Road,	Hagersto	own,	Marylan	nd 21742
נֿי	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 is marked other then "neturel", or Iteme 23a or 28a-1 show other traumatic evant, The Mardical Expending found the collision at		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of	Am	Pate 9,	20c. Loc	cation - City or 1	Town, State
Dallillo	ages ant of t: if i		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			-	natory or other place n Cremat		2007	Hage	rstown,	Maryland
	artme ortan		21. Signature of Funeral Service Licens			22.	Name and Addre		Minnich			
Ö	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1/2 0-000	0:		1			vd., Hag	erst	own, Ma	ryland 2174
	_		23a. Part1. Enter the disease, or comp	lications that caused to	he death. D	o not ente	er the mode of dyir	ng, such as cardia	c or respiratory ai	rest,		Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line			•					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Prostat								years
	Examiner			Due to (or as a	consequenc	e of):						
		4	Sequentially list conditions,	b. Due to (or as a	consequenc	e of):						
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		,						
	xecu al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):						
00/00	be e siciar burii											
0	th certificate be executed tending physician and r use as the burial-transit	an/Medical		0.								
5	certi	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	fpregnancy					2	3d. Date of deli	verv
ă	atter		in the past 12 months?	1□Live birth 2 4□Pregnant at ti			Ectopic pregnancy Other (specify)	у			Month	Day Year
į	The law requires that the death ate has been signed by the atte paga 2 should be detached for	Physici	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown								
ŗ	that led b	효	Part II. Other significant conditions co	ntributing to death but	not resulting	g in the un	iderlying cause giv	ven in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
coras,	uires sign ld be	d by	Lung Cancer						10	res 2₹	No 3□Pro	obably 4 Unknown
5	v req beer shou	Completed	Arterio Scleros	ic					24a. Was	20	24h Were au	toney findings available
į	has ga 2	Ę	- Mitterio beleros	10	-				autor		prior to c death?	topsy findings available completion of cause of
5	n: Ti ficate r, pa	ပိ	25. Was case referred to medical					00.5:	1 ☐ Yes		1 🗆 Yes	2 ☑ No
5	sicial certi recto	0	examiner?	Hospital:			Oth		ath (Check only o			
5	Phys rat d	7	1 Yes 2 X No 27. Manner of Death		t 2□ER/0	. Time of		ner: 4 Nursing F	28d. Describe			cify)
5	ding After fune	ion	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injur Wor M 1 □	rk? Yes 2 □No		,		
IVISION	deat deat ctor: / the	ca	3 Suicide 6 Could not be	28e. Place of Injur	v - At home.	farm, stre			28f. Location (Street and	d Number or Ru	ral Route Number.
<u> </u>	after Dire	Certification;	4 Homicide determined	building, etc.	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To			
_	pita ours ierai filled		29a. Certifier 1X Certifying Phy	/sician: To the best of	my knowled	lge, death	occurred at the til	me date and place	and due to the	cause(s) :	and manner as	stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, paga 2	edicai		iner: On the basis of e	examination							
	o the	Me	29b. Signature and title of central	5			29c Licens	se number		29d. Date	signed (Month	n. Day, Year)
	F ≥ F 0		/////	7)			De	2680	5 1	Ym"	17	2007
			30. Name and address of person who do	ompleted cause of do	ath (Item 22s	a) (Tyne I	Print)		- 7	111	1	
3	H-11+)		Dr. Allen W. Ditto					, Hagerst	own, Mai	cylan	nd 2174	12
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		_		ş.			
	Registi		APD 110	007 /	. 1	1	ele					
DH	MH 17 Rev 1/2	001	DIII LLC	The second		14						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Certificate of Death		Reg. No 007	12952		
ı	Physici		Decedent's Nama (First, Middla, Last) MARGARET M. COLEMAN	2. Data of Das Month APRIL	Dey Yaar	3. Tima of Death		
The state of the s	/Medi Examir		4a Facility Name (If not institution, give street and number) 4b. City, Town, or					
1	LXanın	.ci	GLADYS SPELLMAN NURSING CENTER CHEVER	Ι.Ψ	PRINCE	CFORCES		
	Funeral		5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.	8. Date of Birt		thplace (Stata or Foreign ountry)		
	Director		239-245701 1 M 20XF 82 Yrs. Months Days Hours Min.	JUNE 22	22, 1924 TENNESSEE			
	p. ,	'	Usual Rasidance of Decedent					
	show	_	10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits 1 ▼ Yas 2 □ No		
	Ba-f	Director	MD. PRINCE GEORGES CHEVERLY					
	With the	౼	10e. Street and Number 10f. Zip Coda		10g. Citizan of What Co	ountry?		
	s 23	rai	2900 MERCY LA. 20785	- '' M	U.S.A.			
0	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28s-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 1 Never Married 2 Married 1 Yes, Siva 13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Maxican, Puart of Hyes, Giva 14. Was Decedent Evar in U,S. If Yas, specify Cuban, Maxican, Puart of Hyes, Giva 15. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Maxican, Puart of Hyes, Giva	pacity Yas or No- to Rican, atc.)				
Maryland 21215-0020	raff,	ğ	3 ☐ Widowed 4 🛣 Divorced If Yes, Giva 1 ☐ Yas 2 🛣 No Specify:		Specify:	HITE		
2-0	72 h	Completed	15. Decedant's Education 16a. Decedant's Usual Occupation (Specify only highast grade complated) (Giva kind of work done during most of work	rkina	16b. Kind of Businass	/Industry		
21	igh in the	힐	Elamantary/Secondary (0-12) College (1-4or 5+)	g				
7	ygier Ygier H, IT	S	10 HOMEMAKER		HOME			
ğ	\$ # # \$ \$	Be		na <i>(First, Middl</i> e,	Maiden Surname)			
2	Men Merke Marke	ို		ULA	BEAMAN			
<u>a</u>	12 sh hand hand is m		19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Ru					
	of Haaith Item 27	-	BARBARA WILLIAMS/DAUGHTER 5911 HARRISON AVE., R 20a. Method of Disposition 20b. Place of Disposition (Nama of	LVERDALE Date	, MD. 2073. 20c. Location - City or			
وّر	Pages nent of h int: if its iry or of		1 XBurial 2 □ Cramation 3 □ Removal from Stata cemetery, cramatory or other place)	Date	20c. Location - City or	Town, State		
Ħ	t. Partimer tant:	-	4 Donation 5 Othar (Specify) PARKLAWN MEMORIAL PK.	-9-2007	ROCKVILI	E, MD.		
Baltimore,	permit. Pages 1 and 2 should Department of Haath and Mer Important: If Item 27 is marke any injury or other traumatic pnce.		21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility CHAMBERS FUNERAL F 5801 CLEVELAND AVE					
	2		23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or raspiratory ar	rast,	Approximate Interval Batwaan		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. Ar tevio Sclero the Carolin Due to (or as a consequence of):	WURSZ	JA 18000	Onset and Death		
	₽ #	ner	0.0	, ,	1			
	eath certificete be executed ettending physician and for use es tha bunel-trensit	edical Examiner	Sequantially list conditions, Due to (or es e consequance of):					
Š,	cian a	<u>E</u>	Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Ceuse (Diseasa or injury c.					
68760,	ohysi tha l	900	that initiated avants Pua to (or as a consequence of): resulting in death) Last					
	ding se es		d					
P.C. Box	etter etter for us	la						
j	ha de	ysic	Part II. Other significant conditions contributing to death but not rasulting in the underlying causa givan in Part I.	23b. Did to		a to the causa of death?		
7 <u>.</u>	The law requires thet tha death certate has been signed by the ettendingage 2 should be datached for use	Completed by Physiclan/N	Substatis Henrises/Reginates failure	101	res 2□No 3□P	robably 4 🗹 Unknown		
Records,	uires I sign Ild be	\$ P		24a. Was a	an autonsy 24b.	Were eutopsy findings		
<u>5</u>	v req beer shou	ete	MAME USS Tructure lung Difease	perfor	med?	availabla prior to complation of cause of death?		
e L	has has tge 2	티	Demontra / Atrial Fiz villation	400				
A II di	Ficate 7.			1 U Y		1 ☐ Yas 2 ☐ No		
>	sicia carti	a	axaminer? Hospital: Other:	ith (Chack only or	na) ance 6 □Othar <i>(Spe</i>			
5	Phy rrthis eral o	2:	27. Manner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurrad	спу)		
5	Afte of fun	텵	1 ☑Naturel 5 □ Panding (Month, Day Yaar) Injury Work? 2 □ Accidant invastigation M 1 □ Yas 2 □ No					
DIVISION	After or des octor by th	100	3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, straet, factory, office		traet and Numbar or R	ural Route Number,		
5	s effe al Dir	Certification:	4 ☐ Homicide building, atc. (Specify)	City or Tow	ii, Giale/			
:	To the Hospital or Attending Physician: The is within 24 hours efter death. To the Funeral Director: After this cartificate ha completaly filled in by the funeral director, page?	edical	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledga, daath occurred et the time, date and plece 2□ Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occur and mannar stated.	, and due to the c rred at the time, c	ause(s) and manner as date and place, and due	stated. to the cause(s)		
	o the		29b. Signatura and title of certifiar 29c. Licansa numbar	2	29d. Data signed (Mont	h, Day, Year)		
	11		1 00 00 con 100 001852	-	4 APriZ	2007		
	T	-	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)	1 1				
			30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) A. DE LOCE MAD 4 203 (Vecusbury)	ld Hr	16T/2vi11	8202(1M 8)		
	Stat	e	31. Deta filed (Month, Day, Year) 3 Registrar's Signature		. , ,			
	Registra	100	APR 0 9 2007 there & foote					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** p^{M} April 5, 2007 6:42 Η. Coates Julian /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Ye June 29, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia Year) 1920 5. Social Security Number **Funeral** Months Days Hours 1⊠M 2□F Yrs. 86 579-12-1967 Director Usual Residence of Decedent 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane.
Important: if itam 27 is marked other than "natural; or iteme 23a or 28a-f show enty injury or other traumatic event, the Madical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 TANo Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 1510 Hanby Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 ₩ Widowed 4 Divorced WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Baker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Pearl Oliff Garrett A. Coates ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 706 Justin Way, Silver Spring, MD 20901 Julian H. Coates, Jr./Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition April 10 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Filver Spring, Maryland 21. Signature of Funeral Service Licer Francis Address dorlins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic Shock /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions. It any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto for as a ponsequence of Examine death certificate be executed Hyperkalemia the ettending physicien and resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical Acute Renal Failure IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetaf death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 🔀 No 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation death. 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide ŏ To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of of ridier April 6, 2007 d62999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, #401, Rockville, MD 20852 Petek Donmez, M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9^{Day} **Physician** April 200^{Year} George V. Cossentino 1:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6336 Cedar Lane Apt 366 Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 29, 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Min ^{Year)} 1916 Months 1**⊠** M 2□ F Maryland Director 214 40 5054 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" --- any injury or other traumatic excessions. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane Apt 366 21044 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 12 Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Maintenance Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giovanni Cossentino Julia Occhionero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Cossentino/Niece 12107 Mayapple Trail Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 4-12-2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. Liquiy that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **∏**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Wother (Specify SSt. 1 Yes 2 No 2 ER/Outpatient 3 DOA livq. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: And in by the f 2 Accident 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month

30. Name and address of person who completed cause

strar's Signature

death (Item 23a) (Type, Print)

April 10, 2007

07-02499

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ter Cameron		State of Maryland / Department	artment of ertificate of		and	Mental		20	07 1005
Physici edical Exami		Registrar	CAME			_	2. Date of Dea	Day Year	3. Time of Death 1926 hrs
ulcai Exam		4a. Facility Name (if not institution, give street and number)			vn, or Lo	cation of De	April 1, 20	4c. County of	
		5106 Kenilworth Avenue Apartment #8 5. Social Security Number 6. Sex 7. Age (In yrs.	Inch hidde do a	Edmun		If I had a O	Use In Data of D	Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 Mr. 2 4 7 7 1	Yrs.	If Under	Days	Hours	Min. JUNE 7		9. Birthplace (State or Foreign N.C.
ny		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Location	on					10d Inside City Limits
Maryland 28a-f show any d at once.	'n		YATTSVII						1 X Yes 2 No
Maryla r 28a-f	Director	10e. Street and Number		10f. Zip Co				10g. Citizen of What	
vith the s 23a o e notifi	al Di	5106 KENILWORTH AVENUE # 8 11. Marital Status 12. Was Decedent Ever in U	IS 13 Was	Decedent	2078		(Specify Yes or No	U.S.A	American Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 XNo					erto Rican, etc.)	White, e	etc.
rs after ural", o	by	Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 16a. Decedent	Yes 2			of work done	Specify:	BLACK
5 72 hou in "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				O NOT use		Tob. Tand of Edon	iosomiadony
-003(within giene. her tha	omp	8th 17. Father's Name (First, Middle, Last)	HOMI	EMAKEI		Mother's N	ame (First, Middle,	PRIVA	ATE
21215-0036 21215-0036 Judy be filed within 7 Mental Hygiene. marked other than ic event, the Media	Be C	WILLIAM SEARS			10.			RTER	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiera Important of Tis marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Madical Examiner must be notified at once.	To	19a. Informant's Name/Relationship (Type, Print) CAROLYN FORD/DAUGHTER						mber, City or Town, D, MARYLA	
Baltimore, MD eemit Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati		20a. Method of Disposition 20b.	Place of Disposi crematory or oth	tion (Name			Date	20c. Location - C	
Pages ment of tant: I		4 Donation 5 Other Specify:	RIVERDAI	LE CRI			/10/2007		LE, MARYLAND
Balt permit Departs Import		21. Signature of Funeral Service Licensee						INS FUNEI ER,MARYL	
Physician		23a. Part I. Enter the disa se, or complications that caused the death failure. List only one cruse on each line.							
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Blunt Force In Due to (or as a consequence or condition resulting in death)							Death
		Sequentially list conditions, b							
;	Examiner	if any, Teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	of):						
uted id ansit	Exar	events resulting in death) Last Due to (or as a consequence of d.	of):				X		
e be executed ysician and burial - transit	edical	UNPENDED AMENDED							
8760 tificate ing phys as the b	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the		al death	3	Ectopic pre	gnancy	23d. Date of de Month	elivery Day Year
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and loage 2 should be detached for use as the burial - transi	Physician/M	4 Pregnant at time of d 1 Yes 2 ✓ No 9 Unknown 9 Unknown	leath 5 Oth	er (Specify	/)				
s, P.O. Be ires that the de signed by the	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying ca	ause give	en in Part I.			ite to the cause of death?
ords, P w requires t as been sign should be o			·····				1Ye		Probably 4 Unknown
ecord le law re le has be ge 2 sho	Completed	-						ormed? dea	or to completion of cause of ath? Yes 2 No
	Be Co	25. Was case referred to medical examiner?		26.			eck only one)	2 10	7 163 2 110
of Vital Recoing Physician: The law After this certificate has funeral director, page 2 si	2	examiner? 1 Yes 2 No 27. Manner of Death About 1 Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of Ir			her: 4 Nuat Work?		Residence 6 🗸	
on of ending Ph ath or: After the funeral	tion:	1 Natural 5 Pending Apr 1, 2007	1920 hrs			2 🗸 No	Subject ass		
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) residence		t, factory, o	ffice buil	ding, etc.	or Town,	State)	or Rural Route Number, City
Hospita 24 hours Funcral		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occur	ed at the tir	me, date	and place,	and due to the cau	orth Avenue # 8, I se(s) and manner a	s stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigati				ed at the time, date		
(2)	Σ	29b Signature and title of certifier	1		icense r D.C.M.			April 2, 2007	(Month, Day, Year)
OJE		30. Name and address of person who completed cause of death (Iter						I	
20		Patricia Aronica-Pollak MD. Assistant Medical		111 Pen	n Stre	et, Baltir	nore, MD 2120)1	
Si Regis	tate		we						

/Medi	ian cal	1. Decedent's Nar ROBERT 1	Phy gc mended # me (First, Middle, Las BRUCE CODL	i) ING				2. Date of Dea Month 04	04 Year 2007	
Exami	ner		(If not institution, give ECHWOOD CT Number 6. Se	•	e (In yrs. last birl		ity, Town, or Location of Dea WALDORF der 1 Year If Under 24 Hrs		PRINCE GF	
Funeral Director		384 09 3	3551 ¹	M 2□F /.Ag		Yrs. Mont		. (Month, Day	7 Year 9 21 ROYA	thplace (State or Foreignetty) LOAK, MI
orani win tie mayland	ctor	MD	PRINCE G	EORGES	10c. City, Town	n or Location TEMPLE	HILLS			10d. Inside City Limit
23a or 2	Funeral Director	10e. Street and N	umber EATON STRE	ET		10f.	Zip Code 20748		10g. Citizen of What Co	ountry?
or ite	þ		rried 2 Married 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 1 N If Yes, Give Year or Dates:		If Yes, s	cedent of Hispanic Origin? (specify Cuban, Mexican, Puel 2X) No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: WH	e, etc.
ene. than "netural", to Medical Exe	Completed	(Spe	15. Decedent's Edi ecify only highest grad	de completed)		Decedent's U (Give kind of life. DO NO	sual Occupation work done during most of wo Tuse retired)	orking	16b. Kind of Business/ WASHINGTON	-
Department of Health and Monta comes must be proposed in the properties of Health and Monta and Hygiene and Insportent: If item 27 is marked other than any injury or other traumatic event, ILA M. ODGE.	Be Com		(First, Middle, Last)	College (1-4or 5	CI	VIL EN		me (First, Middle,	AND LIGHT	
1 Menta narked natic ev	ToB		CODLING					E MCCHALI	_	
Ith and 27 is rr r traum			Name/Relationship (T) CODLING/S(•		_	ess (Street and Number or R		•	Zip Code)
item item		20a. Method of Di	sposition		20b. Place of	Disposition (I y, crematory of		Date DOKE	20c. Location - City or	Town, State
ent: If			Cremation 3 🗆 1 5 🗆 Other (Specify,		CEDAR 1			6-2007	SUITLAND,	MD
Departi Importi any inj once.		21. Signature of F	uneral Somo Licens	anha	00	22. Name	and Addr			MD, INC.
hysician /Medical xaminer		23a. Part 1. Enter spock, or he Immediate Cause disease or condit resulting in death	eart failure. List only o (Final ion	a. Page on each lin	a consequence of	ec	node of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	4	Sequentially list c	onditions,	bb. Due to (or as a	a consequence of					
physician and the burial-transit	dical Examiner	Sequentially list c if any, leading to icause. Enter Unc Cause (Disease that initiated even resulting in death)	immediate derlying r injury ts	c	a consequence o	of):				
	<u>a</u>	if any, leading to it cause. Enter Und Cause (Disease that initiated even	mmediate ferlying ferrying ferrying ts; Last	c	a consequence of pregnancy	of):			23d. Date of del Month	ivery Day Year
	by Physician/Medical	If any, leading to i cause. Enter Unc Cause (Disease that indicated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	mmediate ferlying ferrying strains to the strains t	Due to (or as a d	a consequence of pregnancy 2 Fetal death time of death	of): 3 Ectopic 5 Other				Day Year the cause of death?
	by Physician/Medical	If any, leading to i cause. Enter Unc Cause (Disease that indicated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	mmediate ferlying ferrying strains to the strains t	Due to (or as a d	a consequence of pregnancy 2 Fetal death time of death	of): 3 Ectopic 5 Other	(specify)	1 Tye	Month bacco use contribute to as 2 No 3 Pr 24b. Were au prior to contribute to death?	Day Year the cause of death? obably 4 Striknov
	Be Completed by Physician/Medical	If any, leading to cause. Enter Uncause (Disease that indicated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months?	Due to (or as and d	a consequence of pregnancy 2 Fetal death time of death ut not resulting in	of): 3 □Ectopic 5 □ Other the underlyin	g cause given in Part I. 26. Place of De.	1 Yes 2 ath Check only on	Month bacco use contribute to as 2 \(\text{No} \) 3 \(\text{Prior} \) Prior to contribute to death? 24b. Were au prior to contribute to death? 1 \(\text{Yes} \)	the cause of death? obably 4 Oriknov topsy findings availate completion of cause of
n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to: cause. Erner Unc cause (Disease that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? No n ificant conditions co	Due to (or as a d	of pregnancy 2 Fetal death time of death ut not resulting in	of): 3 Ectopic 5 Other the underlyin	26. Place of De Cther: 4 \square Nursing F 28c. Injury at Work?	24a. Was a autops perform 1 Yes 2 ath Check only on Home State Reside	Month bacco use contribute to as 2 \(\text{No} \) 3 \(\text{Prior} \) Prior to contribute to death? 24b. Were au prior to contribute to death? 1 \(\text{Yes} \)	the cause of death? obably 4 Shknow topsy findings availab completion of cause of 2 No
n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to i cause. Erher Unc cause (Disease that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow Part II. Other sign 25. Was case refe examiner? 1 □ Yes 2 27. Manner of Dea	int pregnant 2 months? No n ificant conditions co	Due to (or as and d	of pregnancy 2 Fetal death time of death ut not resulting in	age of the state	26. Place of De Cther: 4 _ Nursing F 28c. Injury at Work? 1 _ Yes 2 _ No	24a. Was a autops perford 1 Yes 2 ath Check only on Home Sept Reside 28d. Describe ho	Month bacco use contribute to ses 2 No 3 Property of the prior to contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior to contribute to the prior	the cause of death? obably 4 Shiknow topsy findings availab completion of cause of
n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	If any, leading to cause. Enter Unicause (Disease that indicated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow Part II. Other sign 25. Was case refe examiner? 1 ☐ Yes 2 27. Manner of Death (Part 2) 28	int pregnant 2 months? No	Due to (or as and d	of pregnancy 2 Fetal death time of death ut not resulting in nt 2 ER/Out y Year) 28b. Ti nn ury - At home, far c. (Specify)	3 Ectopic 5 Other the underlying	26. Place of De Cther: 4 _ Nursing F 28c. Injury at Work? 1 _ Yes 2 _ No	24a. Was a autops perform 1 yes 2 ath Check only on Home September 1 28d. Describe how 28f. Location (St. City or Town	Month bacco use contribute to as 2 \(\text{No} \) 3 \(\text{Prior} \) Prior to contribute to death? 24b. Were au death? 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 5 yes 1 \(\text{Yes} \) 5 yes 1 \(\text{Yes} \) 7 yes	the cause of death? obably 4 Shknow topsy findings availab completion of cause of 2 No val Route Number,
ufter death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	If any, leading to incause. Erner Uncause (Disease that indicated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? In last Interest to medical investigation 6 Could not be determined	Due to (or as a d	of pregnancy 2 Fetal death time of death ut not resulting in nt 2 ER/Out y Year) 28b. Ti nn ury - At home, far c. (Specify)	and the underlying street, fact death occurrence or investigation.	26. Place of De. Cther: 4 _ Nursing \(\) 28c. Injury at \(\) Work? 1 _ Yes 2 _ No ony, office	24a. Was a autops perform 1 Yes 2 ath Check only on Home 28d. Describe how 28d. Location (St. City or Town as, and due to the caurred at the time, d.	Month bacco use contribute to as 2 \(\text{No} \) 3 \(\text{Prior} \) Prior to contribute to death? 24b. Were au death? 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 4 yes 1 \(\text{Yes} \) 5 yes 1 \(\text{Yes} \) 5 yes 1 \(\text{Yes} \) 7 yes	the cause of death? obably 4 Shknov topsy findings availab completion of cause of 2 No wall Route Number, stated, to the cause(s)

			For State Registrar	State of	Marylan		artmen rtificat				-	giene Reg. No	7111	7 12	957
	75		Decedent's Name (First, Middle,	Last)							2. Date of De		•	3. Time	of Death
	Physicia		Robert		Ear1		C	arro	11	Ì	Month	Day O		14	25 M
T.	/Medic Examin		4a. Facility Name (If not institution,	give street and nun					Location of	of Death	UŢ		County of De		~
	LXUIIII		//	ral medii	10/ 10	2600	<	50/	:-h.,,						
2	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Bir (Month, Da	th	NiCOM 9. Bi	rthplace (Stat Country)	e or Foreian
020	Director	5.	220-58-9537	1 X M 2 □ F	54	Yrs.	Months	Days	Hours	Min.	Month, Da 1 – 22 – 19	iy, Yea <i>r)</i> 3 53		hington	n, D.C.
1	D		Usual Residence of Decedent										was	irringtor	1, D.C.
w	how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside	
20	e Ma la-f s tified	cto	MD Prince	George	Riv	rerda1e	2							1 TY	es 2∭ No
2	eno	Jire	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	Country?	
	23a ust b	ral	5305 59th Avenu	e, East				207	737				USA		
	r deg	ne	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	.S. 13.1	Was Deced	lent of Hi	ispanic Ori n. Mexicar	igin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Am Black, Wh		
38	afte or II	Y.	1 ☐ Never Married 2 ☐ Marrie	d 1 ☐ Yes If Yes, Giv	2∰ No e	- 1	1 □ Yes		Specify:		,,		Specify:	110, 610.	
metk 5-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Da	tes:				. ,				эреспу.	White	
anoll 15-0036	be filed within 72 hours after death with the Marylar ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done c	ation during mos	t of worki	ng	16b. Ki	nd of Busines	s/Industry	
N	within ene. than "	E C	Elementary/Secondary (0-12)	College (1-	-4or 5+)										
721	lled v Hygie ther t	ပိ	1.2 17. Father's Name (<i>First, Middle, L</i>	2ct)		Carp	et Ir	stal		w'a Nama	(Final Adiabata		onstru	ction	
anc	ntal hed	Be	T 1	_			_				(First, Middle,	waiden	Surname)		
3 ₹	should be and Menta marked umatic ev	ဥ		denry		Carrol			Haffe		E			urnette	<u>. </u>
2 het Maryland	iges 1 and 2 should the frealth and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationshi			1					l Route Numb			Zip Code)	
		1	Candace Garofolo 20a. Method of Disposition	o- daughte		11039					y, MD			T 01.1	
وّ	Pages nent of I nt: If its iry or or		1 ☐ Burial 2 ☐ Cremation		nate	Place of Dispo cemetery, crer			1				cation - City o		
Baltimore,	permit. Pag Department Important: I any injury o	1	4 □ Donation 5 □ Other (Spe	• •	Cre	emator	y of	De1m	arva	04-1	0-07	Delr	mar, De	laware	
Bal	permi Depal Impol any ir		21. Signature of Funeral Service L	zensee	1/12	22	2. Name an	d Addres	s of Facilit	by Bo	unds F	uner	al Home	2	
	00 = 60	-	Char her	y ko		17	05 E	Main	Stre	eet	Salisb	ury,	MD 218	304	
			23a. Part1. Enter the disease, of a shock, or heart failure. List o	omplications that ca nly one cause on ea	used the death ich line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	GRA	DE !	V SL	LBAI	2A (CHN	DID	HEM	ORR	HAGE	Onset an	d Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consequ	,									
- 6	a second		Sequentially list conditions.	b. RUP	TURE		UTRA	CRA	AINE	LA	NEUR	L751	1		
	pa ##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (d	or as a consequ	uence of):									
	ecute and trans	cam	that initiated events resulting in death) Last	c											11.1
8760,			, seeming in dealin, and	Due to (c	or as a consequ	uence of):									
	physicate the the the the the the the the the t	dical	,	d										 	
Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE:	00 1/	,										
8	ath c	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Feta	I death 3□	Ectopic pr					2	23d. Date of de Month	elivery Day	Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9∏Unkno	int at time of do wn	eath 5∟	Other (sp	ecify)					WOTH	Day	i eai
Division or Vital Records, P.O.	d by letacl	Ph		e contributing to do	ath hut not room	ultime in the co			e in Death		On- Dista				
S,	ires t	ğ	Part II. Other significant condition	s contributing to dea	ani but not lest	uiting in the ui	ndenying ca	use give	m in Pan I.				se contribute t		
or o	requi	Completed									101	/es 2[INO 3M	robably 4 [Unknown
၁၅	law las b	ᇍ									24a. Was		24b. Were a	utopsy finding completion of	s available
<u>=</u>	The page	등									perfo	rmed? 2 No	death?		oddoo o,
/ita	sician: The law secrificate has the continuity of the control of t	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
-	hysic his o	2	1 ☑ Yes 2 ☐ No	Hospital: 1 1 In	patient 2 🔲	ER/Outpatien	t 3□ DO	A Othe	r: 4□ Nu	rsing Hon	ne 5 🗆 Resid	dence 6	3 □Other (Spe	ecify)	
D C	ng P	Certification: To	27. Manper of Death 1 Matural 5 ☐ Pending	28a. Date of (Month)	f Injury n, Day Year)	28b. Time of Injury	2	3c. Injury Work			8d. Describe h				
Sio	endi	äŧ	2 ☐ Accident investiga				М	1 🗆 Y	es 2 🗹	No					
Ξ̈́	ter de	Ĭ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	ed 28e. Place of buildin	of injury - At ho g, etc. <i>(Specif</i> y	ome, farm, stre v)	eet, factory	, office		2	8f. Location (S City or Tow	Street and	d Number or F	lural Route Nu	mber,
Ω	ital c	ë									,	, ,			
	Hosp 4 hou Fune ely fi	ca	(Check only 2 Medical E	Physician: To the bar caminer: On the bar	pest of my know sis of examinat	wledge, death tion and/or inv	occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s)	and manner a	s stated.	(a)
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	Grio)	and manne	er stated.										
	To Cor		29b. Signature and title of certifier	helus -	Mn	Ph D.		License					e signed (Mon		
	1/18		Januar In	,,,,,,	,	1	7)5	404	18		APR	IL 7th	2007	0
	1000		30. Name and address of person w	no completed cause	of death (Item	23a) (Type, I	Print)		A1.00	2,102:-	4.0) ((2) ^	· · · · · · · · · · · · · · · · · · ·		
	10		JACEK M. MAL				TILL K	42./>	71 1 >0	uky	MU, 1	100	T		
	State		31. Date filed (Month, Day, Year)	- F	gistrar's Signat										
	Registra	u e	APR 1 0	2007 19	aur .	H La	2001								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 12958

		1- For State Registrar_	Cert	tificate of	f Death			Re	eg. No.	00	:
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								3. Time of Death	
ledical Exami	ner	PATRICK	MARIO	COOPER				April 7, 20		ar	1034 hrs
		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, o	r Location	of Death		4c. County	of Death	
1		Prince George's Hospita	al Center		Cheverly				Prince C	George's	s
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. la	st birthday)	If Under 1 Ye	ar I If Unde	er 24Hrs.	8. Date of Bir	th(MM/DD/YYYY	/\ 9. Birth	place (State or
Director		010 00 0110		• /	Months Day				Contract of the Contract of th	Foreign	Mashington
Director		219-98-2110	_x м 2 F 35	Yrs				12-18-	19/1	Coul	utry) DC DC
		Usual Residence of Decedent	The state of								40.1.1.69.11.9
r any		10a. State 10b. County		Town or Locat							10d. Inside City Limits
shov	卢	MD PRINCE	GEORGE HYAT	TSVILL	E						1 X Yes 2 No
aryla 8a-f	ŠČ	10e. Street and Number			10f. Zip Code			1	0g. Citizen of W	hat Count	ry?
ne M or 2 fied	Director	8301 HILLVIEW RO	OAD		20785				U.S.A		
ith tl 23a noti		11. Marital Status	12. Was Decedent Ever in U.S	S 13 W/s	s Decedent of H	ispanic Ori	nin? / Sper	rify Yes or No	14 Page	- Americ	an Indian, Black,
st be	Funeral	1 X Never Married 2 Marri	Armed Forces?		es, specify Cuba	in, Mexican	, Puerto R	ican, etc.)		e, etc.	
n i de	Fu		1 Yes 2 X No		·					BLA(CK
s afte	by		ced If Yes, Give Year or Dates:		Yes 2 X N				Specify:		
hour natu	eted	15. Decedent's Education (Specify	, , , , , , , , , , , , , , , , , , , ,		nt's Usual Occup- lost of working lif				16b. Kind of Bu	usiness/in	dustry
6 an " feal !	let	Elementary/Secondary (0-12)	College (1-4 or 5+)								
vithii ene.	Comple		2yrs	R	EALTOR					RIVAI	ľΕ
5-00 led wit Hygien other		17. Father's Name (First, Middle, La	ast)			18.Mothe	r's Name (f	irst, Middle,	Maiden Surname	∌)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medica	Be	HENRY A. COOPER	-15-0:-0:-0:-0:-0			LUCY	BATT	LE			er englister
21 ould d Me	ပ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stre	et and Nur	nber or Ru	ral Route Nur	nber, City or Tov	vn, State,	Zip Code)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nor of stell than dwalled Hygiewith in 12 hours after death with the Maryland it. If item 27 is marked other than "natural", or items 23a or 28a-fabour other traumatic event, the Medical Examiner must be notified at once		LUCY COOPER/MOTH	IER	5601	NORTH MA	RWOOI	BLV:	D UPPE	R MARLBO	ORO,	MD 20772
e, e, land land Healt litem		20a. Method of Disposition		lace of Dispos	sition (Name of c			Date	20c. Location	- City or 1	Town, State
ges cf		1 XBurial 2 Cremation	J Kemovar Irom State	rematory or of			04-1	4-2007	Landove	er. M	m
timen rtant		4 Donation 5 Other Spec			EMETERY						
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minury or other transmatic.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOM)ME	
m 202.5		7474 LANDOVER RD LANDOVER, MD 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or	implications that caused the death. I each line.	Do not enter t	the mode of dying	g, such as o	cardiac or r	espiratory an	est, shock, or he	eart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	a Atherosclerotic ca	ardiovas	cular dis	ease				- Q	Death
zxammer		or condition resulting in death)	Due to (or as a consequence of								
		Sequentially list conditions,	b								
	ē	if any, leading to immediate	Due to (or as a consequence of):						į,	
	Examiner	causa. Enter Underlying Cause (Disease or injury that initiated	С								
sit. 3d	ı,	events resulting in death) Last	Due to (or as a consequence of):							
ecute and - trar			d								
be ex ician	ė	X UNPENDED	#2532,527, perMEG86	7,5/4/07	TΓ						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	n/Medical	IF FEMALE:	23c. If yes, outcome of pregr						23d. Date o	f delivery	
68° ertifi	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fe		Ectop	c pregnan	СУ	Month	D	ay Year
Box 68 e death certi the attendin	Sic	1 Yes 2 No 9 Unkno	4 Pregnant at time of	5 O	ther (Specify)						
the de	Physicia		9 Unknown					100 D: 14		25 A 2 A 2 A	h
P.O.	by F	Part II. Other significant condition	ns contributing to death but not re	sulting in the	underlying cause	given in P	art I.				he cause of death?
res that signed	9		 					1 Ye	s 2 V No 3	Prob	ably 4 Unknown
of Vital Records, ng Physician: The law require this certificate has been sineral director, page 2 should be	Completed							24a. Was auto			opsy findings available ompletion of cause of
CO law law e 2 s	п							perfo	rmed?	death?	
	١Ŝ							1 Yes	2 N	1 Ye	s 2 No
tal Recian: The	Be	25. Was case referred to medical examiner?	Handad. —			e of Death					
this bysic	10	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien		Other ₄		Home 5	Residence 6	Other	:
Of ng P After unera	=	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	· · · I	jury at Wor	_	8d. Describe	how injury occur	rred	
Division tal or Attendiners after death. The Director: A led in by the fu	읥	1 X Natural 5 Pendin	g		1	Yes 2	No				
r Att	<u>[2</u>	2 Accident Investig	28e Place of Injury - At ho	me, farm, stre	et, factory, office	building, e	tc. 2			ber or Rui	ral Route Number, City
Divisior spital or Attend hours after death meral Director:	Certification:	3 Suicide 6 Could r 4 Homicide determine						or Town,	State)		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,									ed.		
he H in 24 he F plete	ica	one) 2 Medical Exami	ner:On the basis of examination ar	nd/or investiga	ition, in my opinio	on, death o	ccurred at	the time, date	and place, and	due to the	e cause(s)
To the within 2 To the complet	Medical		and manner stated.					,			
	2	29b. Signature and title of certifier	1			nse number			29d. Date sign		iui, Day, rear/
		Carganie Von	elshell		0.0	.M.E.			April 8, 20	IU /	
		30. Name and address of person w	no completed cause of death (Item	23a)					•		
		Margarita Korell MD.	Assistant Medical Examine	er 111 F	enn Street,	Baltimor	e, MD 2	1201			
Sf	ate	31 Date filed (Month Day Year)	32. Registrar's Signatu							-	
Regis		31APR 1 (1/3 2007 ear)	Faren H. Soe	the s							

07-02581	
Tyrone Carte	r

April 4, 2007 Year April 4, 2007 Year	e of Death 55 hrs
4a. Facility/Name (if not institution, give streef and number) Peninsula Regional Medical Center Peninsula Regional Medical Center Salisbury Social Security Number Socia	
Director Director	
10a. State 10b. County 10c. City, Town or Location 10d. Ir 12c. City, Town or Location 10d. Ir 12c. City, Town or Location 10d. Ir 12c. City, Town or Location 12c. Ci	(State or
Physician 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.	de) L2/857 tate
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Was underlying to list and the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Was unpended Was unpen	ximate Interval een Onset and Death
The standard of the standard o	Unknown dings available on of cause of 2 No No
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) APR 1 9 2007 32. Posistrar's Signature Registrar	

		-	For State Registrar	State of Mar		ertificate of			leg. No. 200	7 12960
4	Physicia	an .	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	Day Yes	
0.	/Medic	al	William Vernor 4a. Facility Name (If not institution, give		-	4b. City, Town,	or Location of Death	March	4c. County of D	
	Examin	er	Washington Cour	,						
ı	Funeral		Social Security Number 6. S	ex 7. Age (I	n yrs. last birthd	Months Days		8. Date of Birth (Month, Day		gton Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	67	7 Yrs			09/08/1	939 W	ilmington N C
	yland at		10a. State 10b. County	11	Oc. City, Town or	Location				10d. Inside City Limits
	e Mar 3a-f sl	ctor	MD Washingt	on	Hagerst	on, Maryl	and			1 ☐ Yes 2 ☐ No
	a or 2	Funeral Director	10e. Street and Number 11 W Baltimore St	reet #1106		10f. Zip Code 2174	40		IOg. Citizen of What	Country?
	ns 23	neral	11. Marital Status	12. Was Decedent Eve		3. Was Decedent of If Yes, specify Cu	• •	pecify Yes or No-		merican Indian,
3-003e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give 9 Year or Dates.	57-61	If Yes, specify Cu 1 ☐ Yes 2 No		o Hican, etc.)	Black, W	Mhite, etc. White
0	72 ho 'natur dical	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	ecedent's Usual Occu ive kind of work don eDO NOT use retin	upation e during most of wor	king	16b. Kind of Busine	ss/Industry
Z	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	"	Plummer	e <i>a)</i>		Self-Empl	loyed
ב ב	other Jent, t	Be C	17. Father's Name (First, Middle, Last)						Maiden Surname)	
yland	Ments Ments arked atic ev	70 E	James V Durham					Miller		
Ž	and 2 sho saith and 1 27 is m er traum		19a. Informant's Name/Relationship (Irma Miller (Moth	er)	4610	ailing Address (Stree	ee Rd #12	ral Route Numbe 29 Wilmir	ngton, N (28409
palilliore,	ages 1 nt of He : If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		sposition (Name of crematory or other pl Universit		Date 29 20	20c. Location - City	or Town, State
	ortant injury		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		noward	22. Name and Add	ress of Facility	Austin Ro	yster Fur	neral Home
ŏ	Der Imp		▶Terry A Austin	Juft	10	≥ 3821 14t	ch Street	N W Wasl	nington, [C 20011
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line						Approximate Interval Between Onset and Death
į	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	10 M Q		1229	DISC	ase	
	Examiner			bue to to last a	1 DAK 1	- Fne	chalo	ramy		
	it d	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a g	onsequence of):			,		
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
00/00	rificate be executed ng physician and as the burial-transit	alE		d						
00	tificate ng phy as the	l edical		- u.					1	
Š	sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	Physician/∿	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 Live birth 2	Fetal death	3 □Ectopic pregnan	су		23d. Date of Month	delivery Day Year
5	he dea	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death	5 ☐ Other (specify)				,
Τ,	s that the	by Ph	Part II. Other significant conditions					23e. Did to	bacco use contribut	e to the cause of death?
vital Records,	en sig	ed b	77.	abetis trial F	M < 11	itus T	ype L	1 🗆 Y	′es 2 No 3	Probably 4 Onknown
ပ္	law re las be	Completed	(A)	trial F	: bv. 11.	ation		24a. Was a	sy prior	e autopsy findings available to completion of cause of
<u>.</u>	: The cate h	Con						perfo	rmed? deat	h? Yes 2□No
	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ NO	Hospital:	2 🗆 SB/Outos	atient 3 DOA		ath (Check only o	ne) lence 6 □Other (S	2
0	aling Phys I. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Tim	ne of 28c. Inj			ow injury occurred	<i>Бреспу)</i>
	endln ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	ו	ear) Inju	,	☐ Yes 2 ☐ No			
DIVISION OF	al or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc.	- At home, farm (Specify)	, street, factory, office	е	28f. Location (S City or Tow	Street and Number o n, State)	r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (nysiclan: To the best of miner: On the basis of each manner state	xamination and/o					
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licer	nse number	,	29d. Date signed (M	Ionth, Day, Year)
			Jame 1			1)0	,00,596		03/2) \0 /
			30. Name and address of person who	mun	HED	pe, Print)	26 0	cal c	29d. Date signed (M	21740
ı	Sta	ite	31. Date filed (Month, Day, Year)	32. P gistrar's	s Signature	1 5	Hades	2 (1 0 4	,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) April 6,2007 Devine 7:55p M **Physician** Ruth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Burtonsville Holy Cross Rehab and Nursing If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1□M 2₩F 049-07-4133 95 2/23/1912 Connecticut Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in then "natural", or Items 23s or 28s-f show the Medical Executiver must be notified at 1 ☐ Yes 2 ☑ No Burtonsville Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20866 3415 Greencastle Road USA by Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) other than Administrative assistant General Electric 12 27 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Frances Kelly Francis Devine ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3139 Anchorage Dr. Annapolis, Md.21403 Health Martha O'Hehir/Cousin item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 0 = 0 1 Burial 2 ☐ Cremation 3 Removal from State Department of Important: If eny injury or once. St.Michael's Cem 4/14/07 Bridgeport, CT. 4 ☐ Donatish 5 ☐ Other (Spec 21. Signature 7 Funeral Seprice PHILIP Address & NALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final General old age debility **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed 6 mo. Failure to thrive that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) pe 9 Unknown signed by Division of Vital Records. P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ed bluods 1 Yes 2 2 No 3 Probably 4 Unknown Stroke been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2√2 No 1 Yes : After this certifical funeral director, i 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) å 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 9,2007 D0040804 Thomas In 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Ave #342 Silver Spring, Md 20902 9801 Sharma MD Kewal 31. Date filed (Month, Day, Year) APR 10 32. Figistrar's Signature State 2007 Registrar

			1 - For State Registrar	State of	Marylar	-		nt of H te of L		nd M	ental Hyg	ienę	007	12962
	DI		1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month	h Day	Year	3. Time of Death
ı	Physici /Medio		Earl Mic	hael Di	mmick						April	10,	2007	9:45 A.M
	Examir		4a. Facility Name (If not institution, give s	street and numb	ber)		_ ′		Location of	Death			County of Death	
			24411 Kakae Drive		A //	land birdheland		nascu or 1 Year	S If Under 2	A Hrs	8. Date of Birth		Iontgome	
	Funeral Director		5. Social Security Number 579-20-6839 Usuel Residence of Decedent	M 2□F	. Age (In yrs. 83	Yrs.	Months		Hours	Min.	(Month, Day,	Year)	923Wash	place (State or Foreign ntry) ington, D.(
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Man,	to	Maryland Montgon	nery	D	amascu	S							1 ☐ Yes 2X No
	th the	lrec	10e. Street and Number				10f. Z	ip Code			-1	0g. Citi	zen of What Cou	ntry?
	23a c	al	24411 Kakae Drive				2	20872					S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-1 ahow any fujury or other traumatic avant, the Medical Examinat must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 NYes 2 If Yes, Give Year or Dat	es? No		Was Deci If Yes, sp 1 ☐ Yes	ecify Cuba	spanic Origi n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	hour fural	ed b	15. Decedent's Edu		65.	16a. Dece	dent's Us	ual Occupa	ation			16b. Ki	nd of Business/Ir	ndustry
5	n "ne	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)		10r5+)	(Give	kind of w	ork done d use retired	furing most	of workin	ig .			
25	Mily Signature	mo	12	College (1-2	+01 5+/	Con	nstru	ictor				E]	evator	
פ	othe othe vant,	3e C	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle, I	Maiden	Sumame)	
<u>ā</u>	Menta Menta arkad	Tof	Raymond Joseph Dir	mmick							e Hefli			
a	2 sho and is mu		19a. Informant's Name/Relationship (Ty				•	,					Town, State, Zi	
≥,	and ealth m 27		Ann Martin Mewshaw	Dimmic					rive,				land 20	
ore	pes 1 t of H if its		20a. Method ol Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from SI		Place of Dispo cemetery, crea	natory or	other plac	θ) O		3/2007	20¢. Lo	cation - City or T	own, State
Ë	tant:		4 Domestion 5 Other (Specify)	\ F.	A1	1 Souls			у			Gern	antown,	Maryland
Baltimore, Maryland	Departing Department of the poor in the po		21. Signature of Fineral Service Upons	Hill	ram	1 2	Mo16 2640	eswor 1 Ri	s of Facility th-Wildge Ro	lliam oad,	ms P.A. Damascı	, Fu	ineral H Marylan	ome d 20872
8760,	Physician per percented by Medical Examiner properties of the private from	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consecurada a consecurada a	guence ol):			I CLA					Interval Between Onset and Death I y C
P.O. Box 68	The law requires that the death certificate be executed to be associated as been signed by the attending physicien end orage 2 should be datached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Feta ntattime old	aldeath 3[Ectopic Other (s	pregnancy specify)				2	23d. Date ol deliv Month	rery Day Year
	w requires that been signed b should be data	٥	Part II. Other significant conditions con	ntributing to dea	ith but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did tot	Ī	/	the cause of death?
Division of Vital Records,	The law rec ite has bee bage 2 shor	Completed									24a. Was a autops perform		24b. Were autoprior to condeath?	opsy lindings available ompletion of cause of
ita	ician: Th cartificate rector, pag	Be	25. Was case referred to medical examiner?								(Check only on	e)		
<u>~</u>	Physic this ca al dire	To	1 Yes 2 No			ER/Outpatier	nt 3 🗆 🗆			sing Hon	ne 5X Reside	ence (Other (Speci	fy)
ion o	Attanding Physician: r death. actor: After this cartifics by the funeral director, t	atlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	Injury , Day Year)	28b. Time o Injury	f M	28c. Injury Work 1 [] `	vat k? Yes 2 □ N		8d. Describe ho	w injur	y occurred	
Divis	F 8 F C	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o building	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, str fy)	eet, facto	ry, office		2	Bl. Location (St City or Town	reet an n, State	d Number or Rui)	al Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1	sician: To the b ner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurre vestigatio	dat the tim on, in my op	ne, date and pinion, death	d place, a h occurre	and due to the ca	ause(s) ate and	and manner as a place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				2	9c. License	number		2	9d. Dat	e signed (Month,	Dey, Year)
)	ĹΝ.		1 Balelle	1				D450	014			Аp	ril 10,	2007
71	4/1/1		30. Name and address of person who or Dr. Isabella Cater					lwood	Court	t , #1	l11, 01r	iey,	Maryla	nd 20832
*	Sta Registi		31. Date liled (Month, Day, Year) APR 1 0 20	32. 5	gistrar's Signa	ature							-	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 5, Sylvia Eizenstat 2007 4:30 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs 318 03 7598 93 Feb 19, 1914 Illinois Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State rthan "natural", or items 23a or 28a-f show tra Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2151 Montrose Road 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event ODES. Israel Medintz Fannie Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stuart Eizenstat / Son 9107 Brierly Road Chevy Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Greenwood Cemetery 4/6/2007 Atlanta, Georgia 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licen 11800 New Hampshire Ave Silver Spring 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCU MENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. the th 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has 2 No t TYes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: The Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by within 24 hours after To the Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0018084 alli 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD OCKVILLE 6/21 MONTROSE 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) APR 1 (State 2007 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Barbara APRIL 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOOKIVE Espital attimore Johns 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Philippe Toffian 1 □ M 2 🕱 F Months Days Hours Min. 210/34/3960 Director 9/17/1945 Pennsylvania Usual Residence of Decedent with the Maryland show 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Md Director Prince George's Yes 2 No Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be re 7134 Ora Glen Court 20770 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes XXNo 2 Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Domestic d 2 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Sifford Margarett Flowers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Arnold J Ellis, Husband 7134 Ora Glen Crt Greenbelt Md 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to the surface of th Glenwood Cemetery 4/13/2007 Washington DC 4 Donation 5 DOther (Specify) 21. Signature of Functal Service Licen 22. Name and Address of Facility Taylors Funeral Home 1722 North Capital St NW Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any loading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? ģ Month Day Year 4 □ Pregnant at time of death 9 □ Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Funeral Director: stely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after Hospital 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 the 29b. Signature and title of certific 2

State Registrar

			1 - For State Registr <i>a</i> r Amend #5 F	State of Man	yland / Depa	artment of I	Health ar Death	nd Mental Hy	giene	2 A A 7	12065
			Decedent's Name (First, Middle, Last	it)	0/13/01	711		2. Date of D	eath		3. Time of Death
4	Physici /Medi		Margaret S. F	able				Month Apri	Day 1 5,20	07	1:00pm M
	Examir		4a. Facility Name (If not institution, give	,		4b. City, Town, o	or Location of [ounty of Death	1 200 5 2
	The state of the		Carriage Hill Nu			Bethesd				ntgomer	У
24.0	Funeral Director		203-40-7443	ex 7. Age (1. □ M 2 X F 91	n yrs. last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D. Oct 23	rth a <i>y, Year)</i> 3 , 1915	9. Birthp Cour Chica	place (State or Foreign stry)
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				14	0d. Inside City Limits
	leath with the Marylanns 23a or 28a-f show must be notified at	ō	MD Montgor		Bethesd						X□Yes 2□No
	the 1 28a- notifi	Funeral Director	10e. Street and Number			10f. Zip Code			10g Citize	n of What Cour	ntry?
	3a or	Ö	5215 Cedar Lane			2081	4			d State	•
	ter death items 2 ner mus	ner	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.1			n? (Specify Yes or No Puerto Rican, etc.)		. Race - Americ	an Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ \ No If Yes, Give		ir Yes, speciny Cub 1 □ Yes 27□ No		Puerto Rican, etc.)		Black, White, pecify: Whi	
903	ours ural", I Exa	d by	37 Widowed 4 ☐ Divorced	Year or Dates:					S	pecity: WILL	Le
21215-0036	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	f working	16b. Kind	of Business/Inc	dustry
12	within ene. than " he Meo	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	ea)		0	n Home	
d 2	filed Hygi other	ပ္	17. Father's Name (First, Middle, Last)		Home	maker	18. Mother's	Name (First, Middle			
lan	ld be lental ked c	To Be	Robert Truman Sie	ebert				Brach		,	
Maryland	1 and 2 should be filed within Health and Mental Hyglene. em 27 is marked other than ther traumatic event, the Me	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address (Street	I t and Number o	or Rural Route Numb	per, City or T	own, State, Zip	Code)
Σ	and 2 alth a 27 k		Donald Jansky/ So	on				Bethesda,			
Baltimore,	es 1 a of He item		20a. Method of Disposition	Damanal from Otata	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ice)	Date	20c. Loca	tion - City or To	wn, State
<u>Ĕ</u>	permit. Pages 'Department of H Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State	National		1	-8-07	Falls	s Church	h,VA
Salt	permit. Departi Import any inj once.		21. Signature of Foreral Service Lice	see	22	Name and Addre	ess of Facility	er's Sons,	TNC		7.20
	20 5 6 3		fluton 12	W		130 Wisco	onsin A	ve, N.W. W	ashing	gton DC	20016
I	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	00000			rdíac or respiratory a	arrest,		Approximate Interval Between Onset and Death
3.) <u> </u>	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co							
x 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical	IF FFMALE:	Due to (or as a co							
P.O. Box	ires that the death c signed by the attenc be detached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf p 1□Live birth 2□ 4□Pregnant at tim 9□Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	ey		230	I. Date of delive Month	ory Day Year
	uires tha signed I d be det	by P	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
rd	w require been sig should b							_ 1□	Yes 2□I	No 3□ Prob	ably 4 反Unknown
Vital Records,	hysiclan: The law ra his certificate has be I director, page 2 shd	Completed	25. Was case referred to medical					1□ Yes	psy ormed? 2 No	24b. Were autop prior to cor death? 1 ☐ Yes	psy findings available npletion of cause of 2 ੴ No
>	ysicla s cer direct	To Be	examiner?	Hospital: 1 □ Inpatient	2 ER/Outpatien	t 3 DOA Oth		Death (Check only only only only only only only only		Other (Cassif	a
Or	ding Phy n. After thi funeral o		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injui	ry at	28d. Describe	how injury o	ccurred	//
jo	ath. or: Aff	atio	1 □ Accident 5 □ Pending investigation	(Month, Day Ye	ear) Injury		rk?]Yes 2 □ No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	Specify)			City or To	wn, State)		l Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phyone Certifying Ph	rsician: To the best of m iner: On the basis of exa and manner stated	amination and/or inv	occurred at the ti	ime, date and popinion, death	place, and due to the occurred at the time,	cause(s) an date and pl	id manner as st ace, and due to	ated. the cause(s)
	To t To tl		29b. Signature and title of certifier		V	29c. Licens	se number		29d. Date s	igned (Month, I	Day, Year)
	10			Mes	\wedge	He	0 5(2	00	Ц_	6-20	500
	V 0		30. Name and address of person who o				#201 n	1			
			Truong Bao, MD	9715 Medic		r Drive f	FZUI KO	ckville,M	υ Ζ υδ Ͻ ί		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	MAN STANKE					

Darrell Andre Fears State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day April 12, 2007 Year Madical Examiner 1420 hrs Darrell Fears Sr. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 119 Harry S. Truman Drive Apt 44 Largo Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Director Months Days Hours Min 449-11-4446 April29,1955 Country Mexico 1 X M 51 Usual Residence of Decedent any 10a State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No Md Prince George Largo : 23a or 28a-f shov notified at once. 28a-f show hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Harry S. Truman Drive #44apt 20774 USA Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. or items? 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes 3 Widowed 4 X Divorced f Yes. Give Year Yes 2 X No specify: Specify: Black "natural". δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) AD 21215-0036 2 should be filed within 72 ho h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ than the Medical 12th Technician Dept of Treasury Pages 1 and 2 should be filed within tment of Health and Mental Hygiene.
 rant: If item 27 is marked other that or other traumatic event, the Medi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) R.J. Fears Be Nethalier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 20774

COR Mt Tubentia Court East, Upper Mariboro Felder 19a. Informant's Name/Relationship (Type, Print) ဥ Michelle Fears (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State esurrection Cem Clinton Maryland 04/18/07 Donation 5 Other Specify. 0 21. Spinature of Fun and Service Licensee 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW Wash Whe I. Enter the disease or come cation ure. List only one cause on a in line Approximate Interval ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Hypert is ve cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran sician/Medical X UNPENDED #2525,PII,27,perME, g866, 4/24/07 TI Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown the 23e. Did tobacco use contribute to the cause of death? page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Fatty liver due to chronic alcohol use 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No No. 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician; 25. Was case referred to medical of Vital Be examiner? Other₄ Hospital: DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 2 After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the receiving the form of the Funeral Director: Af X Natural Division Yes 2 5 Pending Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eli April 13, 2007 NUD O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2Ŏぴ7 9:23 AM M James Franklin Godlove, Sr. 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington County Homewoood Nursing Home Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

March 24 1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Sex 14 M 2□F Days Hours 84 Maryland 217-16-2592 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Washington Williamsport Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 U.S.A. 16505 Virginia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 2-2

If Yes, Give Year or Dates: 12-2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 2-27-42 1 Never Married Married White 1 ☐ Yes 2 No Specify: 12-2-45 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Machinist

Machinist Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Stouffer Guy Gilbert Godlove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14713 Cearfoss Pike Hagerstown Maryland 21740 James F. Godlove, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a Method of Disposition 1 Duria! 2 Cremation 3 Removal from State 4-16-2007 Hagerstown Maryland Cedar Lawn Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the ode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Priset and Death Immediate Cause (Final (=NO CAN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gunsequants of: Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death that not resulting in the updenying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 15(A) 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No **2** ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner Division or Vital Records, P.O. Box 68760 the death certificate be

physician and s the burlal-trans detached for use as the attending cate has been signed by the page 2 should be detack After this certificate To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica funeral director, filled in by the

Physician

/Medical

Examiner

Funeral

Director

oriant; if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event. The Marian I man

Physician

/Medical

Baltimore, Maryland 21215-0036

204-4+1	
Sta	ıtε
Registr	rai

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Liçense number 29d. Date signed (Month, Dav. Year) 29b. Signature

🏌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MeTwin

4 Homicide

29a. Certifier

Medical

			1 - For State Registrar	State of Maryl	-	artment of H rtificate of I			ene . No. 2 0 0	7 12	968	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ruth Nadine GRIMM			2. Date of E Month April			2007	rear	3. Time of Death	
a.A.	Examir		4a. Facility Name (If not institution, give street and number) 410 North Locust Street 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington			
	Funeral Director		,	M 2⊠F	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		,1921	9. Birthplace (State Country) Maryland		
Maryland 2121	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to fleat had Mental Hygiene. I of Health and Mental Hygiene. or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	I Director	10a. State 10b. County Maryland Washingt		City, Town or Lo					10d. Inside (City Limits	
			10e. Street and Number 10f. Zip Cod 410 North Locust Street 2174					10g	. Citizen of Wh	•		
		by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 △ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc. white		
		To Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wo	rking 16	b. Kind of Busin	,		
			17. Father's Name (First, Middle, Last) Clifford	Sheets			18. Mother's Na	me (First, Middle, Ma Mary Wi				
			19a. Informant's Name/Relationship (7 Carol Grimm - dau					ural Route Number, C eet, Hager			l 2174	
Baltimore,	Pa Fig.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		sition (Name of natory or other place Manor Cen	· · · · · · · · · · · · · · · · · · ·	Date 200 pril 12,2007		ity or Town, State	rv1an	
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	see The		Name and Address 5 East Wi		Minnich F vd., Hager	unera1	Home		
Records, P.O. Box 68760,	ding Physician: The law requir n. After this certificate has been si funeral director, page 2 should	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ARTIRIO b. ARTIRIO	sequence of): SCLIRO sequence of): MGL	CARDIA	L INE	ARCTIO ARCTIO ARTERY D	(\ <u>\</u>	Approximal Interval Be Onset and 5 imie	etween	
		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		Year	
			Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac		ute to the cause of o		
		Completed						24a. Was an autopsy performe 1 Yes 2 V	/ prio	re autopsy findings or to completion of c oth? Yes 2 \(\square\) No	available cause of	
<u> </u>		To Be	25. Was case referred a medical examiner? 1 Yes 2 100	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatien	t 3 DOA Othe	r	ome 5 esidence	e 6 ∏Other ((Specify)		
Division of Vital			27. Mann of Death 1 in atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work M 1 Y		28d. Describe how i				
DIVIS	spitel or Atteno	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or				28f. Location (Stree City or Town, S	n (Street and Number or Rural Route Number, Town, State)			
	9 T 4 J 9	edical	29a. Certifier (Check only one) 1 4 Certifying Phy 2 Medical Exami	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s	s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	M Parional	Physicia	29c. License	number (*)	359 A	Date signed (A	Month, Day, Year)	007	
15	4-1		30. Name and address of person who co	empleted cause of death (I	tem 23a) (Type, F	Print)	TOLIN	1900	1716	2		
	Sta Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	1	,0011,	(14)	i the			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month Physician March 31, Rose Lidia Gonzalez 12:21P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01nev Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 10-7-1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 😾 F El Salvador 547-04-4888 58 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director CA Los Angeles Van Nuys 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7503 Hazeltine Avenue Apt #3 91405 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: El Salvadoran White ģ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonardo Magaña Matilde Olnedo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carlos E. Gonzalez - Husband 7503 Hazeltine Avenue Apt #3 Van Nuys CA 91405 20b. Place of Disposition (Name of cometery, crematory or other place)
Forest Lawn
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If ite
any injury or ot
once. 1 XBunal 2 ☐ Cremation 3 X Removal from State Glendale, CA 4/6/07 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike. 21. Signature of Funeral Service Liberises Rockville MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** metasta disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months Month Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

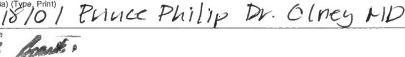
Heatne 31. Date filed (Month, Day, Year) 09

29b. Signature and title of



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

Terrick Lamar Garris UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of	Death		Re	g. No.	
Physicia	in/	Decedent's Name (First, Middle,Last)	-				Date of Deat Month		3. Time of Death
ledical Exami	ner	TERRICK LAMAR GAR	RIS				April 1, 20	07	2230 hrs
		4a. Facility Name (if not institution, give street and number	r)	4	b. City, Town, o	or Location of D	eath	4c. County of Dear	i i
		2727 Firehouse Rd.			Landover	Lieux i a	la Dirick Pire	Prince Georg	
Funeral			ge (In yrs. Ia	ist birthday)	If Under 1 Ye Months Da		Min	h (MM/DD/YYYY) 9. B Fore	ign
Director	l	579-11-3995 13M 2 F	23	Yrs.		,	July 2	8, 1983 C	ountry) MD
>,	-	Usual Residence of Decedent 10a. State 10b. County	Ino City	Town or Location					10d. Inside City Limits
w any									1 Yes 2 X No
Maryland 28a-f show a	ğ	MD Prince Georges 10e. Street and Number	пу	attsvi.				og. Citizen of What Co	
Mar r 28a ed at	Director				10f. Zip Code	_		-	unit y ?
th the 23a o notif		7307 Goodland Dr.			2078		V On a rife. Van an Na	USA	rican Indian, Black,
MD 21215-0036 2 should Mental Higgienein 72 hours after death with the Maryland h and Mental Hygienein 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f she maric event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Force	s?				(Specify Yes or No- lerto Rican, etc.)	White, etc.	FICALL ITIGIAN, DIACK,
er de		1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1	Yes 2 X N	o specify:		Specify: B]	Lack
irs aft iural'	3	or Dates: 15. Decedent's Education (Specify only highest grade or	ompleted)		t's Usual Occup		d of work done	16b. Kind of Business	
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 c		during mo	st of working lif	e. DO NOT use	e retired)		
036 thin 7 ne r thar	힏	12th		Cashi	er			Taco Bel	1e
215-0036 be filed within 72 ntal Hygiene rked other than '	ड	17. Father's Name (First, Middle, Last)				18.Mother's N	lame (First, Middle, N	Maiden Surname)	
21215-00 uld be filed wit Mental Hygien marked other c event, the Me	a	David Garris			0152-71122-2		a Ridley		
21 hould the	ည	19a. Informant's Name/Relationship (Type, Print)						nber, City or Town, Stat	
y, MD 2121 and 2 should be fi ealth and Mental ten 27 is marked traumatic event,		Deidra Garris/Mother 20a. Method of Disposition	Look F		Goodlan Ition (Name of c		Hyattsvil Date	1e, Md. 20	
ore, Nest and of Health If item		1 X Burial 2 Cremation 3 Removal from	State C	rematory or oth	ner place)				
imC Page ment tant: or ot		4 Donation 5 Other Specify:	Li		emorial		4-7 - 2007	Suitland,	MD
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Umportant: I filem 27 is marked other Uniquey or other traumatic event, the Med	. 1	21. Signature of Funeral Service Licensee		Man	rshall rshall	ss of Facility s Funer	al Home,	Inc.	
		23 Part I. Enter the disease, or complications that cause	od the death	Do not enter th	17 9th	St. N.W	. Washin	gton, DC 2	0011 Approximate Interval
Physician /Medical	. 10	failure, List only one cause on each line.			,,,	51	,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Guns Due to (or as a condition)							+
		Sequentially list conditions, b.	,	,					
	je	if any, leading to immediate cause. Enter Underlying Cause	sequence of	·):					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a column of the col	sequence of	F):					
ecuted and transit		d.	,	,					И
lan es	edical	UNPENDED AMENDED							
760, ficate be early physician the burial	Med	IF FEMALE: 23c. If yes, outd	ome of pregi	nancy				23d. Date of delive	
687 certific ding p	an/	23b. Was decedent pregnant in the past 12 months?	at time of de			Ectopic pr	egnancy	Month	Day Year
Box 68' e death certificate attending ed for use as	rsician	1 Yes 2 No 9 Unknown 9 Unknown		ath 5 Ot	her (Specify)				
D. B. the de contract the de ched f	Phy	Part II. Other significant conditions contributing to de		esulting in the u	inderlying cause	e given in Part I	. 23e. Did to	bacco use contribute t	to the cause of death?
, P.O. rres that the signed by I be detached	by						1 Yes	s 2 No 3 Pr	obably 4 🗹 Unknown
ords, * require s been si should b	Completed						24a. Was		autopsy findings available completion of cause of
cords Iaw requires been	npl			-				rmed? death?	,
tal Recian: The certificate ector, page	ဝိ	Top IV.			26 Pla	ice of Death (Ch	1 Yes	2 No 1 🗸	Yes 2 No
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should I	Be	25. Was case referred to medical examiner? Hospital:	itient 2	ER/Outpatient		-		Residence 6 🗸 Oth	ner: Scene
of V ing Phys After thi uneral di	ဥ	27 Manner of Death 28a Date of	niurv	28b. Time of I		njury at Work?		how injury occurred	
ion of tending Pheath. tor: After the funeral	ion	1 Natural 5 Pending FOUND: Da		FOUND:	1	Yes 2 🗸 No	。 Subject sho	t	ı
Division tal or Attendin rs after death al Director: Aled in by the fu	icat	Apr 1, 200 Apr 1, 200 28e. Place of		2200 hrs ome, farm, stree	et, factory, office	e building, etc.			Rural Route Number, City
Divis spital or A tours after neral Dire	ertification:	3 Suicide 6 Could not be determined (Specify) fi	ound lying	in creek be	ed		or Town, S 2727 Firehou	State) se Rd., Landover, M	1d.
Ho 24 h Fun tely	ပ	29a. Certifier 1 Certifying Physician: To the best of	my knowled	ge, death occur	rred at the time,	date and place	e, and due to the cau	se(s) and manner as st	ated.
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination a	ind/or investiga	tion, in my opini	on, death occur	rred at the time, date		
F wit	Me	29b. Signature and title of certifier				nse number		29d. Date signed (A	Month, Day, Year)
14		- Frodre M. hina	TKIN	w.	0.0	C.M.E.		April 2, 2007	
Com		30. Name and address of person who complete ause			111 Donn (Street Pali	more MD 2420	1	
AC.		Theodore M. King, Jr., MD. Assistant			iii Penni	oneer, Darin	more, MD 2120	1	
S Regis	tate	31 Date filed (Month, Davyear) 32. Regis	trar's Signatu	W.					

		For State Registrar	State of Maryland	•	rtment of H			ene g. No.	7 12971
Dhyo	er inion	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
Phys /Me	dical	Lewis E. Gorham					April	8 200	7 3:00 A M
Exam	niner	4a. Facility Name (If not institution, give str			-	Location of Death		4c. County of	
₩. - \$, F	Anne Arundel Medic 5. Social Security Number 6. Sex		ast birthday)	Annapo	DL1S If Under 24 Hrs.	8. Date of Birth	9	Arundel Birthplace (State or Foreign)
Funer Directo		225-05-4515	7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 12,	1920	<i>Country)</i> Virginia
		Usual Residence of Decedent					, , ,		
arylar show	٦	MD Anne Amin		, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2√2 No
he M.	ecto	MD Anne Arun	ide1	Cro	fton 10f. Zip Code		10	g. Citizen of Wh	
11215-0036 within 72 hours after death with the Maryland ene. then "natural", or flame 23a or 28e-f show the Medical Exertirer must be notilised at	Funeral Director	1648 Dryden Way			211	1 /	10	US	
death me 23	era		. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No-	14. Race -	American Indian,
6 after or item	큔	1 Never Married 2 Marned	Armed Forces? 12 Yes 2 No If Yes, Give		Yes, specify Cuba □ Yes 2 No	in, Mexican, Puerto Specify:	Rican, etc.)	Consit (White, etc.
DO3	d by	3 Widowed 4 Divorced	Year or Dates: WW I	Γ '	105 #E INO	эреспу.			White
Maryland 21215-0036 to 2 should be filed within 72 hours aft and Mental Hygiene. 27 is marked other than "natural", or treumstic event, the Medical Exertitions.	Completed	15. Decedent's Educa (Specify only highest grade		(Give I	lent's Usual Occup kind of work done of OO NOT use retired	during most of work	king 1	6b. Kind of Busin	ness/Industry
withir ene.	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		esman	"/		Automob	ile Sales
Hygi ent.	Be Co	17. Father's Name (First, Middle, Last)		Dair	Collecti	18. Mother's Nam	e (First, Middle, M		
lid be lental rked tic ev	To B	Emory L. Gorham				Violet	M. Basta	ain	
shou and N		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town, St.	ate, Zip Code)
is 1 and 2 should be filed within 72 hours the attend and Mental Hygiene. It fleath and Mental Hygiene the Tratural, them 27 is marked other then "natural", other treumstic event, Ira Medical Exa		Mildred V. Gorham /	spouse		Dryden W		ofton, MI		
bermit. Pages 1 ar Department of Hea mportant: if Item iny injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei	moval from State	metery, crem	sition (Name of natory or other place	:e)		0c. Location - Ci	ty or Town, State
Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)	Lake		Mem. Gard				ville, MD.
permit. Pages 1 and 3 Department of Health Important: if Item 27 eny injury or other tre	BCB	21. Signature of Funeral Service Licensee	Powell		. Name and Addre: 512 NW Cr		eall Fune Bowie,		e 0715
29	3	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	Preus	mar	u				Onset and Death
/Medic		resulting in death)	Due to (or as a consequ	ience of):	4				
Examine		Sequentially list conditions, b.	7	one of the					
ed isit	nine .	Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianea cty:					I.
cate be executed physician and sthe burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
siciar b burit	dical E	d							
g phy		0.							
attending p	M/UE	230. Was decedent pregnant	c. If yes, outcome of pregnar		Ectopic pregnancy	,		23d. Date	
he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de 9 Unknown		Other (specify)			Month	n Day Year
ed by the a	Phy	9 ☐ Unknown Part II. Other significant conditions contri		Iting in the	adorhina asusa siii	on in Part I	23a Didtoh	acco use contrib	ute to the cause of death?
signed b	Completed by Physician/Me	metastati	Monthly to dealth but not resu	Com	Lenying cause giv	on III Fail I.	1 ☐ Ye	L.	☐ Probably 4 ☐Unknown
been s	etec		7				24a. Was an		
has ge 2	E C						autopsy perform	pric ned? dea	ere autopsy findings available or to completion of cause of ath?
fficate or, pa	င္ပ	25. Was case referred to medical				OC Place of Page	1 ☐ Yes 2	No 1L	Yes 2 No
nysician: The law his certificate has t I director, page 2 s	0 0	examiner?	spital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	or	th <i>(Check only one</i> ome 5 ☐ Reside		(Specify)
ig Phys terthis neral di	n:	27. Manner of Death		28b. Time of Injury			28d. Describe ho		
Attending Physician: The law requires that the death certific death. - deat	atio	1	(Month, Day Foar)	,ury		Yes 2 □ No			
ter de lrecto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
Hospitel or 24 hours afte Funerel Dir tely filled in I									
hin 24 hours after death. the Funerel Director: After thin pletely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occu	, and due to the ca rred at the time, da	use(s) and mann ite and place, an	ner as stated. d due to the cause(s)
To the To the	Ž	29b. Signature and title of certifier	0 00 NY	20	29c. Licens	e number		-	Month, Day, Year)
10	/	Van Us	vej!	14/		0021	7 /1	04/09,	/ 200 /
C)	0	30. Name and address of person who com Paul Berez, M.D.	pleted cause of death (Item 2225圧 Do	23a) (Type, 1) チアカシ	Print) P Hwy	Cro.	fton,	mp o	21114
	State	31. Date filed (Month, Day Year)	225E Do	ure		,		IV L	7
Regi	strar	APR I U 2001 Free	w N. Kyou						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kenneth E. Griffin April April 2007 05:03 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehabilitation Center Anne Arundel Edgewater 6. Sex Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 07/06/1949 9. Birthplace (State or Foreign Year) 1 X M 2 □ F Months Days Hours Min. Maryland 214-54-2294 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 United States 1332 Malboro Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Annapolis Flooring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Griffin Helen Woods 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Griffin/Wife 1332 Marlboro Road, Lothian, Maryland 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 TxBurial 2 ☐ Cremation 3 ☐ Removal from State Moses Cemetery 04/06/2007 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signatur of Funeral Service Licensee Kaler 2973 Solomons Island Road, Edgewater, Maryland 21037 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer year Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24a. Was an autonsv

Physician /Medical Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

Director

Funeral

ģ

Completed

Be

Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760

o.

۵.

Division or Vital Records,

or Attending

Hospital

death.

n 24 hours after death.

The Funeral Director: A pletely filled in by the fu

within 2

completely

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

burial-tran physician s the burial as use for ed by the signed to Jas page 2: certificate director this After th funeral

Exami

Physician/Medical

2

Completed

Be

P

Certification:

Medical

29a. Certifier

in the past 12 months? 1 ☐ Yes 2 ☐ No laryngeal cancer

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perform 1∐ Yes 2 X No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 【X No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0062534 04/04/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rita Dhawan, M.D., 144 Washington Road, Edgewater, Maryland 21037 31. Date filed (Month,

State Registrar APR 0 6 2007

			State of Maryland / Department of Health and Mental 1- Registrar Certificate of Death	2017	12973
			1. Decedent's Name (First, Middle, Last) 2. Date	of Death	3. Time of Death
	Physicia /Medic		Morry H Cott		7:20 A ^M
	Examin		A. E. W. M. C. Tanada M. C. Tan	4c. County of Dear	th
	-		Calvert Manor Healthcare Center Rising Sun	Cecil	
-	Funeral		1110 01 0000 LIW 4AJ Yrs '	th, Day, Year) Co	hplace (State or Foreign buntry)
ومقترة	Director		Usual Residence of Decedent	1 16, 1923 M	laryland
	yland now at		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mar na-fst	cto	Maryland Cecil Elkton		1 ∐ Yes 2 X No
	or 28	Funeral Directo	10e. Street and Number	10g. Citizen of What Co	ountry?
	ath w	ral	1592 St. Augustine Road 21921	USA	
	items	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (Specify Yes Free Proces) 1 □ Never Married 1 □ Never Married 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	or No- 14. Race - Ame c.) Black, Whit	
39	urs af	þ	If Yes, Give 1 Yes 2 No Specify: Year or Dates:	Specify: Wh	ite
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business	
21	ithin 7 ne. nan "i	nple	to (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		
	led w lygier her th			Own Home	e
Maryland	l be fi ntal H ed ot ed ot	Be	<u> </u>	,	
Z	should nd Me mark matic	ို	Richard Callahan Mary Hogate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route I		Zip Code)
	nd 2 salth al		Francis Gott/ Husband 1592 St. Augustine Road, E	1kton, MD 219	21
Jre,	ss 1 a of Hei item		20a. Method of Disposition 20b. Place of Disposition (Name of complete y cremetery cremetery cremetery and personal parts)	20c. Location - City or	
imo	Page nent c		1 🛣 Burial 2 🛣 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bethe1 Cemetery 4-12-200	07 Chesapeake	City, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifled at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Hom	e. P.A.	. 1
-	₹0 = 8 0		School 318 George Street, Ches	apeake City, I	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line.	tory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a	Jue/	1month
	Examiner		Otte to (or as a consequence of):		70 (160
	30.16 0	ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	^7	TEW Years
	outed d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	/	•
oʻ	ate be executed hysician and the burial-transit				
8760,	ate b	dical			_
89 x	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy	001.04	
Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of del Month	Day Year
0		ıysi	1 Yes 2 Not 9 Unknown 9 Unknown		
٣.	requires that the een signed by th hould be detache			Did tobacco use contribute to	the cause of death?
or Vital Records,	w require been sig should b	Completed by	3 Chrilen Janine	1 Yes 2 No 3 P	obably 4 Junkhown
ecc	law as b	plet	I I Im I was all dependent Drahett 24a	. Was an autopsy 24b. Were autopsy prior to	utopsy findings available
= E	0 12	Com	mellith) - 1	performed?death?	_
Vita	Physician: The this certificate al director, pag	Be	© 25. Was case referred to medical examiner?	only one)	
or	Phys this c	<u>۲</u>	1 Inpatient 2 EH/Outpatient 3 DOA 4X Nursing Home 5	Residence 6 Other (Spe	cify)
on	Attending F r death. ector: After by the funera	tion	27. Mann f Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Desi 28d. Des	cribe now injury occurred	
Division	Atten r deat ector by the	ifica	Suicide Sui	tion (Street and Number or Re	ural Route Number,
Ö	s after	Certification:	4 Homicide determined building, etc. (Specify)	or Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			to the cause(s) and manner as	s stated.
	the H the F the F	Medical	one) and manner stated.		
	To Veit		29b. Signature and title of certifier 29c. License number 29c. License number	29d. Date signed (Mont	n, vay, rear)
	1		20 Marga and address of parson who completed desirant death (Nom 22a) (Tura Driet)	-1/0//	200/
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ELICTON	M) 21921
	Sta	te			
	Registr	ar	APR 1 0 2007 Stewn St. Sparter		

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

APR 2 3 2007

State of Maryland / Department of Health and Mental Hygiene 1- State AMEND#23a, PT1, & Pt. 2perMD, 4/1040710205 of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Day **Physician** 7:58 PM Gertrude Jackson Harris March 28, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital
Social Security Number 6. Sex 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 **Funeral** Year Months Davs Hours Min 1 □ M 2 🗓 F 68 Virgínia 1938 Director 229-44-4628 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show the notified at 1 X Yes 2 □ No Director DC Washington, DC 10g. Citizen of What Country? 10e. Street and Number items 23a c 2225 Savannah Terrace, S.E. 20020 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s may Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Viola Jackson Willie Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2805 Ivy Bridge Road, Ft. Washington, MD Tonya Wiggins/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 7,2007 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility AGEE/MCKINNON Funeral Service 3821 14th Street, N.W., Washington, DC 20011 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pneumonia a Pneumonia & Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Acute Respiratory Distress Syndrome Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Acute Renal Failure Acute Respiratory Distress Syndrome that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Acute Renal Failure Gastric Carcinoma IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Gastric Carcinoma 24a Was an autopsy performed? Yes 2 No page 1□ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral I

completely filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62520 March 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria D'Arbela MD 1500 Forest Glen Road, Silver Spring, MD 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State APR 10 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Wilbur Scott HOOPENGARDNER April 10, 2007 10:47 a.M /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Somerford House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 15,1917 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months 1XM 2□ F Maryland 207-01-5998 89 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1X Yes 2 No Hagerstown Maryland Washington Directo 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code With USA 21742 162 Sunbrook Lane Peges 1 end 2 should be filed within 72 hours after deeth nent of Heelth and Mental Hygiana. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) public school system educator other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Elsie Bottenfield John Hoopengardner ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9831 Meadow Valley Drive, Vienna, Va. 22181 f Heelth Roger Hoopengardner - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: If ite
eny injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 4/13/07 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c) as a consequence of. or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes l paga 2 s autopsy performed? certificete 1 Yes 2 No 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Matural 5 Pending within 24 hours are: cc...
To the Funeral Director: Alt 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 9 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) of person who completed cause of death (Item 23a) (Type, Print) 3H-10 7355 TV1 11110 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Betty Lee HAMBY April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14811 Cearfoss Pike Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. 82 Sept. 6 1924 West Virginia Director 236-22-5190 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rthen "naturel", or items 23s or 28s-1 ehov the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14811 Cearfoss Pike 21740 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Her own home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Ann Sensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester E. Hamby, Sr. -Husband 14811 Cearfoss Pike, Hagerstown, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Broadfording Cemetery 4/14/07 Hagerstown, Maryland 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heimers **Physician** Due to (orde a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) o the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 1 🗌 Yes 2150 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient ၉ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending Natural 2 Accident 5 Pending Injury within 24 hours effer death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wary E. Woney, MD 354 /4://S MD Huserstown 354 Willst 31. Date filed (Month, Day, Year) APR 1 32. Registrar's Signature State 11 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5^{Day} **Physician** Hugh R. Hammond April 1 200⁷ ar 8:25A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 91 Days Hours Year) 1915 401-16-5522 1 XM 2 ☐ F Yrs Director June 4, Kentúcky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at Prince George's Maryland Lanham 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 7306 Riverdale Road United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ½Yes 2 □ No If Yes, Give Year or Dates: 1942~1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Retail furniture, 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) home furnishing, clothing Sales Person other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Mary Evelyn Humphries Hugh Robert Hammond, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. Margaret T. Hammond -wife 7306 Riverdale Road Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/6/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 0,150 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-trar that the death certificate be exec Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Alzheimer Dementia 2 No 1 Tyes 3 ☐ Probably 4 ☐Unknown certificate has been si rector, page 2 should ! Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 X No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 \(\text{Nursing Home} \) Hospital: 1 💢 Inpatient 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending F after death. I Director: After d in by the funera Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral E 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053235 April 5, 2007

State Registrar

31. Date filed (Month, Day, Year)

APR

09

rson who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M			rtment <i>tificate</i>			nd Me		iene) () og. No.	- Carrier - Carr	12979
	Physic /Medi		Decedent's Name (First, Middle, Last) Nancy Lee Holt								2. Date of Deat Month April 6	Day	Year	3. Time of Death 3:02
4	Examir		4a. Fecility Name (If not institution, give Holy Cross Hospital	street and number)				fown, or L	ocation of	Death		4c. Cour	nty of Death	19102
	Funeral Director		215-44-4354	7. Ag	je (In yrs. last bin 62	hday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day, July 9,	Year)		
	the Maryland 28a-f ehow	Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Montgomen 10e. Street and Number	EY	10c. City, Town		Spring				11	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ № 0	
336	2 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at	by Funerai Di	10921 Inwood Avenue,	#408 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		11				SA ace - Ameri lack, White,	can Indian,			
21215-003	ed within 72 hou ygiene ier then "neture t, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementasy/Secondary (0-12)		5+)	(Give	ent's Usual kind of work OO NOT use Inteer	k done du	on ring most	of working	g	Holy (dustry Ospital
Maryland	o = 0 ≥	To Be	17. Father's Name (First, Middle, Last) Theodore McKinley Ho 19a. Informant's Name/Relationship (Ty		100	N 4 - 12 -			Luci	lle M	(First, Middle, M	stan		
	1 end Heelth em 27 ther tr		Gary T. G. Carey/Compar 20a. Method of Disposition	•	20b. Place of	921 Dispos	Inwood	Aveni	ue, #4		Route Number,		20902	
Baltimore,	permit. Pages Depertment of important: If it eny injury or o		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		Gate of	Heav	Ancis	etery	flins		Si al Home 1	nc.		aryland
08/60,	Physician /Medical Examiner but style part of the par	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Obstructi Due to (or as	ive Sleep a consequence of a consequence of a consequence of	Apne	er the mode				Silver Strespiratory arre		10 2030	Approximate Interval Between Onset and Death
.C. BOX	the death certifis by the attending pached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pre Other (spe						ate of delive	ery Day Year
ds, r	w requires that the de been signed by the a should be detached	þ	Part II. Other significant conditions con Obesity	tributing to death b	ut not resulting in	the un	derlying ca	use given	in Part I.			acco use co		he cause of death? pably 4 🖾 Unknown
	The la ate has page 2	Completed									24a. Was ar autopsy perform 1 Yes 2	,	prior to co death? 1 Yes	psy findings available mpletion of cause of 2 No
Division of Vital	ding Phys h. After this funeral di	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Day		ime of jury	M 28	c. Injury a Work?	4 🗆 Nurs	sing Home	Check only one e 5 Reside d. Describe ho	nce 6 □O	urred	
2	ospital or Atten hours after deat unerel Director; ly filled in by the	O	4 Homicide determined 29a. Certifier the Certifying Physical Systems (Charles and Charles)	28e. Place of Injubuilding, etc	of my knowledge	death	occurred a	t the time	date and	nlace an	City or Town	State)		al Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	(Check only 2 Medical Examirone) 29b. Signature and title of certifier	and manner sta	examination and	vor inv	estigation, i	License n	umber	occurred	at the time, da	te and place d. Date sign	e, and due to	the cause(s)
	1		30. Name and address of person who co	mpleted cause of d			•	d255				April	6, 200	07
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 9 200	32 Registra	ar's Signature	don.	WE THE	A LID	20310					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 April Charlotte Ruth Hais 1:10 P. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ROCKVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 24, 1919 Rockville Nursing Home Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 485-09-7264 Director Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examiner was the motified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No Directo Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5135 Fairglen Lane 20815 U. S. A. Funeral 14. Rece - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Anna Goldstein Louis Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5135 Fairglen Lane, Chevy Chase, Maryland 20815 Alan B. Hais - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/5/2007 * 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Gdns Falls Church, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, Maryland 20852 Donald. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) HTHEROSC 1edr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 No 2.X No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 🗙 No Other: 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: in 24 hour.
The Funeral Directory filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Na e and address of person who i omplet cause of death (Item 2 a) (T e. Prin. 31. Date filed (Month, Day, Year) oristrar's Signature APR 09 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

APR 1 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Warren J. Hutchinson

		1- For State Registrer Certificate of Death Reg. No. 2017 12982
Physici Medical Exami		1. Decedent's Name (First, Middla,Last) WARREN J. HUTCHINSON JR. 2. Data of Death Month Day March 28, 2007 3. Tima of Death 0820 hrs
		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bon Secours Hospital 4c. County of Death Baltimore
Funeral Director		5. Social Sacurity Number 5.77 68 4300 1 X M 2 F 55 Yrs. 55 Yrs. 55 Yrs. 55 Social Sacurity Number 5. Social Sacurity Number 5. Social Sacurity Number 5. Social Sacurity Number 5. Social Sacurity Number 5. Social Sacurity Number 6. Sex 7. Aga (fn yrs. last birthday) 1 If Under 1 Year 1 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign WASH). Country) D. C.
ow any		Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMORE 1 X Yes 2 No
Aaryland 28a-f show any <u>1 at once.</u>	Director	10e. Straet and Number 10f. Zip Coda 10g. Citizen of What Country?
with the h s 23a or e notifie	ral Dir	3508 COLDSPRING LANE 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black.
s after death v ras", or item	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No spacify: Armed Forces? White, etc. 1 Yes 2 No spacify: Specify: BLACK
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "mannan", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be motified at once.	Completed by	15. Decedent's Education (Specify only highast grade completed) Elementary/Sacondary (0-12) Collega (1-4 or 5+) 1 2 Collega (1-4 or 5+) UNKNOWN 16b. Kind of Businass/Industry UNKNOWN UNKNOWN
1215-0036 I be filed within 7 ental Hygiene. arked other than vent, the Medica	Be	17. Fathar's Name (First, Middla, Last) WARREN J. HUTCHINSON SR. 18. Mother's Name (First, Middle, Maiden Surname) VIVIAN OWENS
MD 21 rd 2 should lift and Me m 27 is ma	To	19a. Informant's Name/Relationship (Type, Print) ROBIN H. COLE/SISTER 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Coda) 1385 ADAMS ST., N.E. WASH. DC. 20018
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Bygene, Important: If item 27 is marked other thinjury or other traumatic event, the Med		20e. Method of Disposition 1 Burial 2 **Cramation 3 Removal from State 4 Donation 5 Other Spacify: 20b. Place of Disposition (Name of cemetary, Date crematory or other place) RIVERDALE CREMATORY 4/7/07 RIVERDALE MD.
		3435 14th ST., N.W. WASH: DC. 20010
Physician /Medical xaminer		23a. Partif. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Just to (or as a consequence of): Approximate Interval Between Onset and Death
	er	Saquantially list conditions, if any, leading to immediata Dua to (or as a consequence of):
	Examine	cause. Enter Undarlying Cause (Disease or Injury that initiated evants resulting In death) Last Due to (or as a consequence of):
executed ian and ial - transit		UNPENDED AMENDED
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Completed by Physician/Medical	FFEMALE: 23c. If yes, outcome of pregnency 23d. Date of delivery 23d.
P.O. s that the gned by t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis, Chronic Obstructive Lung Disease, Siezure Disorder 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown
cords, Flaw requires has been sign 2 should be	leted	24a. Was an 24b. Were autopsy findings available
		autopsy perior to completion of cause of death? 1 ✓ Yes 2 No 25. Was case referred to medical 26 Place of Posth (Check solves)
Vital hysician: this certiff	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Finneral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b	ation: T	27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be detarmined Could not be detarmined (Spacify) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State)
To the Ho within 24 To the Fir completely	edic	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) March 29, 2007
e		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner, 111 Penn Street, Baltimore, MD 21201
St: Regist	ate rar	31 APTRICA (MONT2007 Car) See 32. Regularies See 32

			1 - For State Registrar	State of	Marylar		artmen rtificate				lental Hy	giene Reg. No:		12983
36	Physici	an	Decedent's Name (First, Middl	e, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		STEFAN	HERBE							04	05	2007	04-301M
	Examir	er	4a. Facility Name (If not institution		,				Location	of Death			County of Death	
	Function		PRINCE GEORGES 5. Social Security Number		HOSPI 7. Age (In yrs.		-	VERL 1 Year	Y If Under	24 Hrs.	8 Date of Bir	PI th	RINCE GE	
	Funeral Director	ķ	577-80-3259	1 ∑ M 2□F	46	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 10,	y, Year) 196	O Washi	place (State or Foreign htry) Lngton, DC
	p ,		Usual Residence of Decedent								,1dy 10 ,	170		
	ehov	7	10a. State 10b. County			ty, Town or Lo							1	1 Ves 2 No
	the M	ecto	Maryland Prince	e George's	Fo	restvi		0-4				10. 00	/ / / / / / / / / / / / / / / / / / / /	
	with sa or	בַּ	2120 Brooks D	rive #315			10f. Zip	2074	7				zen of What Cour	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-1 show other traumatic event, the Madical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		ed State	
ထ္	or Ite	Fu	1 ☐ Never Married 2 ₹ Mar		2 🕅 No					i, Puerto	Rican, etc.)	- 1	Black, White,	
993	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 🗌 Yes 🔞	ZIŽĮ NO	Specify:				Specify: Bla	ack
Maryland 21215-0036	"natu	Completed		t's Education st grade completed)		(Give	dent's Usua kind of wor	k done a	urina mos	t of work	ing	16b. Kir	nd of Business/Inc	dustry
72	withir ene. then	Jup	Elementary/Secondary (0-12)	College (1-	4or 5+)	IITO.	DO NOT us Truc		, civer				Privat	D
۵ 2	filed Hygid other	Ö	17. Father's Name (First, Middle,	Last)			1140	וע א.		er's Name	e (First, Middle,	Maiden .		
<u>a</u>	outd be Mental arked o	To Be	William Her	bert					(Glor	ia Walk	er He	erbert	
ary	and Men marke		19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a					Town, State, Zip	Code)
	1 and 2 Health a em 27 la		Gloria Walke	r Herbert		2120	Brook	s Dr	ive #	315	, Fores	tvil]	le, Marv	1an <u>d 20747</u>
altimore,	of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Demoval from S		Place of Dispo cemetery, cres	sition (Nan	e of		(Date		cation - City or To	
Ē	Pages Iment of tent: if its		4 Donation 5 Other (S		Met	ropoli	tan C	rema	tory	4/	10/07	Alexa	andria,	Virginia
3a l	permit. Pages Department of Importent: If II any injury or o		21. Signature of Funeral Service	Licens		22	2. Name and	d Addres	s of Facilit	y5538	8 Marlb	oro I	Pike	
	40360		23a. Part1. Enter the disease or	Jung 1	0108	Po	pe Fu	nera	1 Hon	nes,	P.A. F	orest	tville,	MD 20747
8	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	r as a conseq	ver	Cic	No	Sis	cardiac (1651,		Approximate Interval Between Onset and Death
8/60,	certificate be executed right physician and use as the burial-transit	icai Examiner	Sequentially list conditions, Tary, leading to himbediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq									
99	rtifical ng phy as th			1										
ñ.	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pre Other (spe					2	3d. Date of delive Month	ery Day Year
ت. ت	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant condition		ith but not resi	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did to	bacco us	se contribute to th	ne cause of death?
D .	w require been sig should b	ed b) ep	Sis							1 🗆 Y	es 2	No 3 ☐ Prob	ably 4 Unknown
Hecords,	law re	Completed	·								24a. Was		24b. Were auto	psy findings available
r	Fe he he	E						•			autop perfo	rmed?	prior to cor death? 1 \(\sum \text{Yes}	inpletion of cause of
VITA	sician: certifica irector, p	Bec	25. Was case referred to medical examiner?			-			26. Place	of Death	Check only o		1 105	2 🗔 140
5	S S	2	1 ☐ Yes 2 🗑 No		patient 2	ER/Outpatien	t_3 DO	A Othe	r: 4 🗆 Nui	rsing Ho	me 5 🗆 Resid	lence 6	Other (Specify	v)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 Pendin 5 Pendin	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Bc. Injury Work	at ?		28d. Describe h	ow injury	occurred	
DIVISION	Attending r death. ector: After by the fune	Certification:	2 Accident investig	not be	(1-1		М		es 2 🗆					
=	or Attendanties of Direction by	arti	4 Homicide determ	ned 286. Place o	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str /)	eet, factory,	office		1	28f. Location (S City or Tox	Street and vn, State)	Number or Rura	I Route Number,
	Hospitel or 14 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifyin	g Physician: To the b	est of my kno	wledge death	Occurred a	at the time	e data and	d place .	and due to the			
:	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examinal	tion and/or inv	estigation,	in my op	inion, deat	th occurr	ed at the time,	date and	place, and due to	the cause(s)
	within 2	Me	29b. Signature and Mis of gertified	5				License					signed (Month, I	
	(1)		· /4/1/11/	MD.			1	000	063	580	5	06	+-05.2	2007
00/0	0/		LACA LL	who completed cause	· 11	N 1	Print)		,	(1.	000		1 h	i
<i>y</i> (_				000/		es lito	NU	104	-6		everle	1/ /L	10.	
	Sta	le i	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture							1	

		1 - For Stata Registrar	State of Maryla			t of H	ealth a		lental Hyg	_	-	12984
Physicia	an	1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	h Day	Year	3. Time of Death
/Medic		WILLIAM D. H							APRIL		007	3:00 A
Examin	er	4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	of Death		4c. County	of Death	
		321 CHESTNUT STRE			If Under		ERDEF				ARFO	
Funeral Director			7. Age (in y	rs. last birthday)	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) JUNE 23	Year)		lace (State or Forei try) RYLAND
Maryland -f show lied at		10a. State 10b. County	10c.	City, Town or Lo	ocation						1	0d. Inside City Lim
Mar B-1 sl	ţo	MARYLAND HARE	ORD		ABERD	F:FN						1 XYes 2 ☐ 1
n 72 hours after death with the Marylar "natural", or fleme 23a or 28a-1 show callest Examinet must be notified at	Director	10e. Street and Number			10f. Zip				1	0g. Citizen of W	hat Coun	itry?
23a	ra	321 CHESTNUT STRE	ET				2100)1		US	SA	
Iteme	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		- Americ , White,	an Indian,
hours after lural; or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give		1 🗆 Yes 🔞	No	Specify:			Specify:		
"natural",		15. Decedent's Edi	Year or Dates: 1951		dent's Usua	I Ossus	tion.					
in 72 n "nal	Completed	(Specify only highest grad	le completed)	(Give	kind of wor DO NOT us	k doné a	uring most	of workir	ng	160. Kind of Bus	iness/inc	austry
e filed within all Hygiene. I other then "vent, It a Ma	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	HEAVY				RATO	R	US GO	VERN	MENT
e filed of the vent,	o l	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, I			
should be nd Mental marked o	To B	WILLIAM DAVID HOO	KS				LEON	A PR	ISCILLA	MONK		
s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other then other traumatic event, I.e.M.		19a. Informant's Name/Relationship (T)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	l Route Number	City or Town, S	tate, Zip	Code)
1 and 1 Health Iem 27		EUGENE KELLY / SC	N	321	CHEST	TUV	STREE	T, A	BERDEEN	MARYLA	ND 2	21001
of Ho of Hi if iter		20a. Method of Disposition 1		. Place of Dispo cemetery, crei	sition (Nam natory or of	e of her place	9)	D	ate	20c. Location - 0	ity or To	wn, State
Pag ment ant: ury c		'4 Donation 5 Dother (Specify)	U	INU NOIV	TED M	ETH	CEM	4/11	1/07	ABERDE	EN, I	MARYLAND
permit. Pages 1 an Deportment of Heal Important: If item 2 any njury or other		21. Signature of Funeral Service Licens	m Cole	nan 22	LISA 552	SCO FWT	s of Facility IT FU	NERA	L HOME,	P.A.	' MT	21079
Physician	22 3	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the de ne cause on each line.		er the mode	of dying	, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons		vac.	Cen	1				141	EE - 17
cuted nd ransit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	to SNO c							US GOVERNMENT den Sumame) MONK ty or Town, State, Zip Code) MARYLAND 21001 Location - City or Town, State ABERDEEN, MARYLAND CA. Approximate Interval Between	
cate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consi	equence of):								
Hospitel or Attending Physicien: The law requires that the death certificate be executed 3.4 hours after death. Funerel Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital déath 3 🗆	Ectopic pre							•
igned by be detac	by Ph	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use contrib	ute to the	e cause of death?
w require been sig should b									1 🗌 Ye	s 2 No 3	Proba	ably 4 □Unknov
The law rate has be page 2 sho	Completed								24a. Was ar autopsy perform	pri led? de	or to com ath?	sy findings availab apletion of cause of
elcien: Th certificate irector, pag	ø.	25. Was case referred to medical					26. Place	of Death	Check only one		1 1 05	2 140
hyelc l direc	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	t 3□ DO	Othe	P*		e 5 k eside		(Specify))
uttending Ph death. ctor: After th / the funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28 M	c. Injury Work 1 🗆 Y	at	2	8d. Describe ho			
el or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory,	office		21	8f. Location (Str City or Town	eet and Number State)	or Rural	Route Number,
To the Hospitel or, within 24 hours after To the Funerel Dire completely filled in E	Medical (29a. Certifier (Check only one) Cartifying Physical Cartifying Ph	sician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a restigation,	t the time	e, date and nion, death	place, ar	nd due to the ca d at the time, da	use(s) and mani te and place, an	ner as sta d due to	ated. the cause(s)
To the within 2 To the complet	¥	29b. Signature and title of certifier Plasticul (Shulde, no			License	number 8050)		d. Date signed (Day, Year)
+IVA		30. Name and address of person who co Prashant Shukla	mpleted cause of death (Ite	om 23a) (Type, 1	e Stre	et#	= 400) Ab	erdeen!	4D 21	001	
State Registra	е	31. Date filed (Month, Day, Year) APR 1-0 2007	32. Registrar's Sign	nature	,							

State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 Month **Physician** Year April 9, Evelyn Irene Harvey 2:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home 0akland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Sept. 28, 1905 West Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F 213-74-7513 Director 101 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 **∑** Yes 2 □ No MD Garrett 0akland Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 238 500 Glades Square 21550 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Ite marked other then "netural", or Ite any jujury or other traumatic event, the Medical Examira once. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide 8 Home Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles William Lantz Laura Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura J. Cummings/ Daughter 57 Dilley Road, Oakland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aurora Cemetery 4/14/07 Aurora, WV 21. Signature of Funeral Service bic insee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Coronary Artery Disease Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-translt Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 💹 No Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation after death Director: / d in by the f 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death becomed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier (Check only To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H26154

DHMH 17 Rev 1/2001

Registrar

69 Wolf Acres Road, Oakland, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

32. Registrar's Signature

Dr. P. Daniel Miller,

APR 1 3 2007

31. Date filed (Month, Day, Year)

4/10/07

			1 - For State Registrar	State of Marylan	d / Depa	artment	t of H	ealth a		ental Hy	giene	07	12986
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ath		3. Time of Death
П	Physici		Genevieve 1	1 Hunt					*	April 1	Day	2007	2346PM
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location o	f Death	10111		inty of Death	2010
	LAGITIII	iei	Chester RiverH		Her	CI	100	erto	wn		(/	ont	-
	Funeral		5. Social Security Number 6. Sex	00		If Under		If Under 2		8. Date of Birt	h	9. Birthpl	ace (State or Foreign
	Director		077-18-1087	^{™ 2} XF 86	Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Day July 8,	^y 1 ^y 2 ^y 1	Coun	New York
	פ		Usual Residence of Decedent										
	how		10a. State 10b. County	10c. City	y, Town or Lo	cation						10	Od. Inside City Limits
	Ma Ma	ō.	Maryland Queen Ar	ne's Che	sterto	own							1 ☐ Yes 2 📉 No
	th th	ire	10e. Street and Number			10f. Zip	Code				10g. Citizen	of Whal Coun	try?
	238 L	aic	301 Hoffecker Roa	ıd		216	520				USA		
	dea	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	ent of Hi	ispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	- 14. I	Race - America Black, White, e	
9	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1	1 ☐ Yes 2		Specify:	, , , , , , ,			ecify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "naturet", or itema 23s or 28e-f show he Madical Exemiret must be notitied at	Q p	3 XWidowed 4 □ Divorced	Year or Dates:			- <u>Q. 1</u> 140	ороспу.			Spe	scny. WIII	
2	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usua kind of wor	k done o	during most	of workin	ıg .	16b. Kind o	f Business/Inc	lustry
2	ithin of of of	id I	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us	e retired,)					
7	e filed wall Hygier other the		12	2	Homen	laker						Home	
밀	be fit d oth	Be	17. Father's Name (First, Middle, Last)	· an						(First, Middle,		name)	
Z la	should nd Men marke umaric	၉	Louis A. Deferrar							K. Hes			
Maryland	2 sh and and ts m		19a. Informant's Name/Relationship (Ty							Route Numbe	-		Code)
	and lealth m 27 her t			laughter				Road		stertow			
9	iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan efficient of Heath and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or itema 23s or 28a-f show njury or other traumatic event, the Medical Examinet must be notified at a		20a. Method of Disposition 1 🏋 Burial 2 □ Cremation 3 □ R		lace of Dispo emetery, crer	sition (Nam natory or ot	ne of ther place	e)	Da	ate	20c. Location	on - City or To	wn, State
≣	meniment:		4 ☐ Donation 5 ☐ Other (Specify)		mpton			-		9,2007			Maryland
Baltimore,	permit. Pages 'Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service License	9,115	F.	Name and	d Addres	s of Facility	hein.	& New	nam Fi	mera1	Home PA 107780055
ш_	205 2 9	1 1	23a. Part1. Enter the disease, or compli	efelier								1620 4	107780055
	/Medical Examiner prusitions of paral-transitions o	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last	bue to (or as a consequence to (or as a consequence).	uence of):	virs 200	17	- S	eve	ere		4	Interval Beween Onset and heath
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□ eath 5□	Ectopic pre	ecify)	on in Part I		23a Did to			ry Day Year e cause of death?
ds,	signé signé d be d	d by	no to me		14 W 6	Judiny Hig Co	-aac gird	er, mir oxiti.			res 2□N		V/
Ö	w require been si should t	etec	ucourt re		VI 3								
Vital Record	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this cartificate has I completely filled in by the funeral director, page 2	Completed					-			24a. Was autop perfor 1 Yes		b. Were autor prior to con death? 1 Yes	osy findings available inpletion of cause of
⋚	Physician: this certificanal director, I	Be	25. Was case referred to medical examiner?	ospital:			Othe	· ·		Check only			
ŏ	Phy rthis raldi	J.	1 Yes 2 No	1X npatient 2 □ 1 28a. Pate of Injury	ER/Outpatien 28b. Time of		A Bc. Injury	4 🗆 1401		ne 5 ☐ Resid 8d. Describe h)
C	ding h. Afte fune	tio	Natural 5 ☐ Pending	(Month, Day Year)	Injury	м	Work	? /es 2 □ N		od. Describe i	iow injury oc	carred	
2	Attending r death. •ctor: After by the fune	ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm str					9f Location /S	Stroot and Ni	imber or Rura	l Route Number.
Division	lor A effer Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify	')	oot, tadory,	, 011100		-	City or Ton		mbor or ribra	riodio riambor,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in I		29a. Certifier Certifying Phys	sician: To the best of my know	wledge, death	occurred a	al the tim	ie, date and	d place a	nd due to the	cause(s) and	manner as et	ated
	e Ho Fur	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation,	in my op	pinion, deat	h occurre	d at the time,	date and place	ce, and due to	the cause(s)
	Vithin Forth	₹ e	29b. Signature and title of certifier			29c.	. License	number			29d. Date sig	ned (Month, I	Daf, Year)
•	-> H 0		1/200			T	11/	,44	2 9		4	14	107
		7	3D. Name and address of person who co	mplete cause of death (Item	23a) (Type	Print)	1	1			100	/ / /	O /
			Wayne DIS	ediamini	40	()	286	Je v	TOW	on A	12	716	20
	Sta	te	31. Date filed (Month, Day, Year)	/32. Registrar's Signal	ture			1 - /	1		~ /	<u>- V</u>	
	Registr	ar	ΔPR 0	6 200>	as All	Mont	Maria A	ę.					

amend line 8 per fd aaco hith dept 4/10/07 dlw

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 11 **Physician** WARD HITCHINGS 04 03 pm 2007 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SYKESVILLE (OPPER RIDGE 710 OBRECHT ROAD CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2□ F Days Hours Months Director 122-22-1535 Usual Residence of Decedent 11, 1925 parmit. Peges 1 end 2 should be filed within 72 hours effer death with the Manyland Depertment of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show empty injury or other traumatic event, tre Medical Examiner must be notified at DRGs. 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 Yes 2 No Funeral Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 967 Shadewater Way 21401 United States 12. Was Decedent Ever in U,S. Armed Forces?

1 X Yes 2 No 194
If Yes, Give 104 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1943 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 1945 Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Wood Elementary/Secondary (0-12) College (1-4or 5+) Construction Industry Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Ethel Celestia Wilber Horace King Hitchings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol H. Hitchings / Wife 967 Shadewater Way Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 4/5/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner use es the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? hes 1 🗆 Yes 1 □ Yes 2 □ No 2 No r: Aftar this cartifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No မ 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completally filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical and manner stated. \$ 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature end title of certifie who completed cause of death (Item 23e) (Type, Print) 30. Name and eddress of person Willy 295 Stone 31. Date filed (Month, Day, Yo State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year arence 4c. County of Death 2030 /Medical amuc 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804 WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F 213-22-8117 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rust be notified at Be Completed by Funeral Director 1 Yes 2 □ No WILLOMIC 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 or Iteme 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status other treumetic event, the Medical Evantuer 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other than ' Elementary/Secondary (Q-12) College (1-4or 5+) grade 17. Father's Nam (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 I 208 WINTERBOON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Date 1 Burial 2 ☐ Cremation injury or 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Arress of Facility Zabula 23a. Part1. And the disease or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Approximate Interval Between Onset and Death Pnysician disease or condition resulting in death) /Medical Due to ra, a consequence of): Examiner esquentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed 218 19:00 Due 6 (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 by Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Year 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1□ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 0 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Lursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel [🚅 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 2 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 31. Date filed (Month Par Year) 0 32. Registrar's Signature State Registrar

•	
07 00775	
07-02775	

ichael Steven		1- For State Certifi	nent of Health and Mental H cate of Death		200	7 1200
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	. No.	3. Time of Death
ledical Exami	ner	Michael Steven Humler		Month April 12, 20	Day Year 07	0630 hrs
		Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	n	4c. County of Death Anne Arundel	
Famous		5. Social Security Number 6. Sex 7. Age (In yrs. last b		s. 8. Date of Birth	(MM/DD/YYYY) 9. Birti	hplace (State or
Funeral Director		212-96-6866 1\(\text{X}\text{M}\) 2\(\text{F}\) 26	Yrs. Months Days Hours Mir	_	Foreign	
J cow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland Anne Arundel Riva	vn or Location			10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	itry?
th the Maryland 23a or 28a-f sho	Dire	3200 Douglas Point Court	21140	U	Inited States	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shr r traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14_ Race - Ameni White, etc.	can Indian, Black,
after ral", o	by F	3 Widowed 4 Divorced of Pass Give Year or Dates:	a. Decedent's Usual Occupation (Give kind of	west done	Specify: Whi	
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	tired)	Tob. Kind of Business/ii	ndustry
36 hin 72 than than	ompleted	4	ales & Service Specialist		Banking	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	S	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, M	aiden Surname)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than c event, the Medica		Paul E. Humler	Edith R. 19b. Mailing Address (Street and Number or		City on Town State	7in Code)
imore, MD 21215-00; Pages I and 2 should be filed withinent of Health and Mental Hygiene. Iant: If item 27 is marked other the other traumatic event, the Med	ြ	19a. Informant's Name/Relationship (Type, Print) Paul E. Humler/Father	3200 Douglas Point Court			, Zip Gode)
e, M and 2 Health item 2 traur		20a. Method of Disposition 20b. Place	te of Disposition (Name of cemetery, natory or other place)	Date	20c. Location - City or	Town, State
norges		1 M Burial 2 Cremation 3 Removal from State		17/2007	West River,	Marvland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature of Europe Parice Transfer	22. Name and Address of Facility Geo	orge P. Kal	as Funeral Ho	me, P.A.
		23a. Part I. Enter the disease, or complications that caused the death. Do	2973 Solomons Island I	Road, Edgew	ater, Marylan	d 21037 Approximate Interval
Physician /Medical		failure. List only one cause on each line.		or respiratory arre	st, shock, of ficult	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic and alcoho Due to (or as a consequence of):	I intoxication			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.				
uted utd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
60, ate be executed hysician and be burial - transit	Medical	X UNPENDED AMENDED 27,28a-f, pe	rME, g866, 4/26/07 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnan 1 Live birth 4 Pregnant at time of death 1 Unknown		nancy	23d. Date of deliver	y Day Year
O. B at the d lby the tached		Part II. Other significant conditions contributing to death but not result	Iting in the underlying cause given in Part I.		bacco use contribute to	
ires that the signed by be detacled	d by				2 No 3 Prot	
of Vital Records, ng Physician: The law requir Wher this certificate has been s nneral director, page 2 should l	Completed			24a. Was a	sy prior to o	topsy findings available completion of cause of
Recol The law icate has	omi			perfor 1 ✓ Yes 2		es 2 No
Of Vital Reing Physician: The After this certificate uneral director, pagg	BeC	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 V FR	26.Place of Death (Chec		Residence 6 Othe	
f Vi Physi er this	욘	1 Yes 2 No	VOutpatient 3 DOA VIIII Nurs 3b. Time of Injury 28c. Injury at Work?	•	Residence 6 Othe	
on of Nating Ph. th. r: After the funeral	ion:	1 Natural 5 Panding (Month, Day, Year)	1 Yes 2 X No	unknown		
Division tal or Attendir rs after death. al Director: A	ficat	2 Accident Investigation FIRE 4/11/2007 FI	nd 5:30 am and	28f. Location (S	treet and Number or Ru	ıral Route Number, City
Div pital o ours afi eral D	Certification:	4 Homicide determined (Specify) Other Sci	ene	33 Dean S	t. #1 Annapol	is, MD
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, ar or investigation, in my opinion, death occurred	nd due to the cause I at the time, date a	e(s) and manner as stat and place, and due to the	ed. ne cause(s)
F. 2 F. 8	Me	29b. Signature and title of certifie	29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Califul 210.	O.C.M.E.		April 12, 2007	
		30. Name and address of person who completed cause of death (Item 23 Zabiullah Ali, M.D. Assistant Medical Examiner	^{a)} 111 Penn Street, Baltimore, MD 2	1201		
	tate		(hails)			
Regis DHMH 17 Rev 1/2			ORIGINAL			
		•	- · · · · · · · · · · · · · · · · · · ·			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Day Bertha J. Ham April 16 2007 9:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 729 Earlton Road Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□M 2MF 217-22-4254 Director 100 Yrs 1906 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow Examiner must be notified at Director 1 ☐ Yes 2 No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 729 Earlton Road Iteme 23a 21078 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onen of Heath and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ò Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John D. Roten Zilphia Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Rodney F. Ham (Son) 725 Earlton Road, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It eny injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State Bel Air Mem. Garden 04/20/2007 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, PA 123 S. Washington St., Havre de Grace, MD Part 1. Enter the disease, or committations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mush **Physician** disease or condition resulting in death) /Medical Due tox(or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year P.O. 1 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death Check only on examiner' Hospital: Other: 4 Nursing Home 5 Lesidence 6 Other (Specify) Medical Certification: To 1 Yes/ 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Many of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural To the Hospins after death, within 24 hours after death.

To the Funerel Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) MW

State

Registrar

31. Date filed (Month, Day, Year)

APR 23

2007

whim

32. Pagistrar's Signature

filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Box 68760. P.0. Records, Vital To the Hospital or Attending Physician: 0 Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** H, HOAM William George Johnson Apr 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 89 Director 107-03-9430 Jan. 12, 1918 Canada Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 11114 Mapleville Road U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Representative Aircraft permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph E. Johnson Grace M. Burkitt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11114 Mapleville Rd. Hagerstown, Maryland 21742 (Wife) Marcella M. Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 12 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home M01414 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Alzheimers Dementia **Physician** disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and as the burial-trar Due to (or as a consequence of): Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X1 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform rmed? 2.⊠No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.D. Suite 130, Hagerstown, Maryland 21742

State Registrar Vr George Newman I

APR 1 3 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

11110 Medical (

32. Registrar's Signature

Division or Vital Records, P.O.

Registrar

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 7:35 PM^M April Lerov С. Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6330 Crickett Hill Road Westover Somerset If Under 1 Year | If Under 24 Hrs. | Months Days Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 82 09-07-1924 Pennsylvania 196-14-0816 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be redified at 1 X Yes 2 □ No Director MD Somerset Westover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21871 USA 6330 Crickett Hill Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status NS Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Jones Mildred Staub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra Norma Jean Jones/Wife 6330 Crickett Hill Road, Westover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/13/2007 Milford, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Milford Community Cem 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical **Examiner** Examiner burial-transit attending physician and Medicai Certification: To Be Completed by Physician/Medical as the t the detached signed by should be has

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. neral Director: After this c filled in by the funeral dire within 24 hours To the Funeral

disease or condition resulting in death)	a. Due to (or as a consequence of):	noma ot	PAVICI	eas	ment
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
that initiated events resulting in death) Last	c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect	opic pregnancy ner (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.		ouse contribute to	o the cause of death?
			24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
25. Was case referred to medical		26. Place of Deal	th (Check only one)		
examiner? 1 □ Yes 2XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3	B DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐Other (Spe	city)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not i 4 ☐ Homicide determined		factory, office	28f. Location (Street City or Town, Sta		ural Route Number,
	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.				
29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Mont	h, Day, Year)
Charle	Stant Do.	1442911	4	1-10	-07

MO 21851

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 1 1 2007

10

person who completed cause of death (Item 23a) (Type) Print)

32. Registrar's Signature

٥7	-02	39	8	

Clarence L. Johnson	1-	Jr. For State egistrar	State	of Maryland		rtment of		nd Ment	tal Hygi		g. No. 2	00	7 12991	
Physician/ Medical Examine	1	. Decedent's Name (First, Clarence L			r.					Date of Deat Month larch 28,	h	Year	3. Time of Death 0915 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De								iaicii 20,	h				
Funeral	5	3 Kimberly Court Social Security Number	6. Se:	x 7. /	Age (In yrs. Ia	ast birthday)	Severna F		r 24Hrs. 8.	Date of Birt		Arundel	rthplace (State or	
Director		219-04-02	51 ₁ X	M 2 F		38 Yrs	Months Da	ays Hours	NAID.			1968 CounMaryland		
ż	_	Jsual Residence of Decede			Inc. City	Town or Locat	ion						10d. Inside City Limits	
id Se.				undel		no1d							1 Yes 2 No	
Maryland 28a-f she d at once	1	0e. Street and Number		<u>-</u>			10f. Zip Code		-	10	Og. Citizen of	What Cou	intry?	
th the Nature 123 or notified	5	71 E. Joyc	e Lar				210				USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Higgine. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Marital Status Never Married 2	Married	12. Was Decede Armed Force			is Decedent of F es, specify Cub					ace - Amer /hite, etc.	rican Indian, Black,	
s after of	٦L			If Yes, Give Year or Dates:		1	A-	No specify:				^{fy:} B1a		
2 hours "natu		15. Decedent's Education Elementary/Secondary (ly highest grade o			nt's Usual Occup ost of working li			done	16b. Kind of	Business/	Industry	
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan		12th		0		Pri	inter						Printing	
15-0 filed v all Hygin ed other		7. Father's Name (First, M		C				1			faiden Surna	me)		
2121 ould be fi d Mental I s marked tic event,	1	Clarence L 9a. Informant's Name/Rela	ationship (Ty	rpe, Print)	<u>r .</u>	19b. Mailing	g Address (Str	reet and Num	alle ber or Rural	Watt Route Num	ber, City or 1	own, State	e, Zip Code)	
MD and 2 she salth and 2 she salth and salth and salth and salth and salth and salth		Cynthia Jo	hnsor	n(Wife)	1 20h E		Clay St			olis,			Town, State	
Baltimore, pernit. Pages I an Department of Hee Important: If ite njury or other tr		1 Burial 2 X Crer		Removal from	State	rematory or ot	her place)							
altim mit. Pa partmen portant ury or o	2	Donation 5 Oth 1. Signature of Funeral Se		see	ме		emato:		4-3-0 Sons				e, Md.	
		Lovy & . K		100483		82	21 West	t St.	Anna	poli	s, Md	. 21	401	
Physician /Medical	ı	3a. Part I. Inter the disea failure. List only one of	ause on ea				he mode of dyin	ig, such as ca	ardiac or res	spiratory arre	est, shock, or	neart	Approximate Interval Between Onset and Death	
Examiner		mmediate Cause (Final dis or condition resulting in de		Oue to (or as a co										
, de	5 1	Sequentially list conditions f any, leading to immediate	9 [Due to (or as a co	nsequence of	f):					_			
ted Instit Examiner	(cause. Enter Underlying C Disease or injury that initial events resulting in death)	ited C.	Due to (or as a co	nsequence of	f):								
executed an and al - transit														
50, e be execu ysician and burial - tra		UNPENDED		AMENDED	ama of acon						22d Date	of deliver	<u> </u>	
6876(certificate nding phy- se as the b	23	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Date of delivery Month Month Month Date of delivery Month Month Month Date of delivery Month									Day Year			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit hvs.ician/Medical Ex	[]	1 Yes 2 No 9	Unknown			ath 5 Ot	her (Specify)							
P.O. B that the d med by the detached	- F	Part II. Other significant o	onditions	contributing to de	ath but not re	esulting in the o	underlying caus	e given in Pa	art I.				the cause of death?	
duires the quires the uld be defended										1 Yes			bably 4 Unknown utopsy findings available	
(ecords, the law requires are has been signage 2 should be completed								-	_	autop perfor 1 V Yes	med?	death?	completion of cause of	
ing Physician: The law requires that the After this certificate has been signed by Tuneral director, page 2 should be detach by Tro Be Completed by P	ر ا د	25. Was case referred to m	edical			_	26.Pla	ace of Death ((Check only		2 110	1 🗸 Y	es 2 110	
F Vita Physicia rrthis ce al direc		examiner? 1 ✓ Yes 2 N			atient 2	ER/Outpatient		Other ₄	Nursing H		Residence		er: Scene	
on of Nating Ph. th. : After the funeral		27. Manner of Death 1 Natural 5	Pending	28a. Date of I (Month, Da Mar 28, 20		28b. Time of 0915 hrs	_	njury at Work Yes 2 ✔	Sui		now injury oc t by police			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within E4 hours abler death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the behalviral Certification: To Be Commisted by Physician/Me	2	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.								28f. Location (Street and Number or Rural Route Number or Torus, State)				
Dispital of spital of hours and ineral I	ר ר	On Codifice												
To the Hos within 24 h Volume 124 h Europhetely	בן בו	Charle ante	ing Physici Il Examiner	an: To the best of	xamination a	ge, death occu ind/or investiga	rred at the time, tion, in my opin	, date and pla ion, death oc	ace, and due curred at the	e to the caus e time, date	se(s) and mar and place, ar	ner as star nd due to t	ted. he cause(s)	
9 N N N N N N N N N N N N N N N N N N N	2							cense number			29d. Date signed (Month, Day, Year)			
		Patu les	Eni	01	lex -	200	0.0	C.M.E.			March 2	9, 2007		
14	3	30. Name and address of p Patricia Aronica-F			of death (Item t Medical I		111 Penn	Street, Ba	altimore, I	MD 2120	1			
Stat Registra	e 3	31. Date filed (Month, Day	Year) 4 2	007 32. F. gis	trar's Signatu	ire	and a							
DHMH 17 Rev 1/2001	-11					ORIGINA	L	-						

			For State Registrar	State	of Mar	yland /		artmen tificate			and M	ental Hy	/gienę Reg. Nó:	2 [] [] [1 129	95		
	Physici	an	Decedent's Name (First, Middle,									2. Date of D Month	Day	Yea	3. Time of I	-		
	/Medic	al	Clyde			45 (25)	Tau	I continu		April		County of D		> PM				
	Examin	er	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital Baltimore										40.	County of D	eam			
F	uneral			. Sex		(In yrs. last b	irthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of B	irth	9. 8	Birthplace (State or Country)	Foreign		
	irector		212-60-1552	1 🔼 M 2 🗆 F	53		Yrs.	Months	Days	Hours	Min.	June 2	1, 19	953	Maryland			
pug	≥ 152111		Usual Residence of Decedent 10a. State 10b. County		1	10c. City, Tov	wn or Lo	cation							10d. Inside Cit	y Limits		
ING 21215-UU36 be filed within 72 hours after deeth with the Maryland ital Hygiene. Ind other then "natural", or items 23s or 28s-f show event, the Modical Examiner must be notified at	٥	Maryland			Balt									1 ∑Yes				
	Directo	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What	Country?				
	al D	322 South Monro	e Stree	t		21223							S.A.					
	Funeral	11. Marital Status	Armed	Decedent Ev	er in U.S.	13. \	Vas Deced	lent of Hi	ispanic Orig	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	0-	merican Indian, hite, etc.					
S affe	, or if	by Fu	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📆 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:				1 ☐ Yes 2 🖾 No Specify:							Specify: Black				
Z1Z15-0036 d within 72 hours af	al E	edt	15. Decedent's	16a	a. Deced	dent's Usua	I Occupa	ation			16b. Ki	16b. Kind of Business/Industry						
61. 27. pig 2	Machine Machine	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				(Give	kind of woi DO NOT us	rk done a	turing most	t of workir	ng .	,					
N P	t a	Com	12				Por	rter					1	ıperma	rket			
e -	d oth	Be (17. Father's Name (First, Middle, La									(First, Middle						
Sould blood	narke natic	10	William Leroy Kelly						(0)			enriet			- 7:- C- d-)			
Mar 12 sh 12 sh h and 7 ie m traum		19a. Informant's Name/Relationship Pamela Dorsey /					-				<i>i Route Numi</i> e. Wes			Maryland	2115			
			20a. Method of Disposition			20b. Place	of Dispo	sition (Nan	ne of	1	D	ate			or Town, State			
mo Pages	y or		1 🖾 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		om State	Locus	t Ui	natory or o	Met	hodis	t //	16/07	Co1	ımbia,	Maryland	1		
Baltimore,	inju		21. Signature of Funeral Service Li			A		. Name an	d Addres	s of Facilit	У							
n a	8 E E B		Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872												2			
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												veen				
		Immediate Cause (Final disease or condition										TWOW						
	ledical aminer		resulting in death)	Due	to (or as a	consequence	of):											
		e	Sequentially list conditions, flany, leading to animodiate cause. Enter Underlying	CURSACIUMNOS	nos off.													
petr	ınsit	min	cause. Enter Underlying Cause (Disease or injury that initiated events		,													
6U , be executed	ial-tra	Examine	resulting in death) Last	C. Due	to (or as a	consequence	uence of):											
9	ysician and he burial-transit	icai																
.O. BOX 68 the death certifica	attending ph for use as th	Med	IF FEMALE:															
BOX ath ce	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?						3 Ectopic pregnancy					23d. Date of delivery Month Day				
. ရှိ ရ	ed by the a deteched t	yslo	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)9 Unknown															
T ta	d bet	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa							en in Part I.		23e. Did	e to the cause of de	eath?				
rds guire	been sign should be	q pa	SACRAL ULCER									10	Yes 2□No 3□Probably 4▼Unknown					
Hecords, P	2 sho	piet	SACRAL ULCER									24a. Wa	Was an 24b. Were autopsy find utopsy prior to completion			available		
VITAI RECOLUS licien: The law requires	page 2	Completed										perl	iormed? 2 No	death	1?	1030 01		
/Ita	is certificate director, pag	Be (25. Was case referred to medical examiner?		- 1:				Tai		of Death	(Check only	one)					
Of VITA Physician:	al dii	5	1 ☐ Yes 2 No 27. Manner of Death	-	Inpatient ate of Injury		utpatien Time of			4 🗆 Nu		ne 5 □ Res 8d. Describe			Specify)			
C 5	nei nei	tion	1*⊠Natural 5 ☐ Pending	(A	Wonth, Day		Injury	м	8c. Injury Work	rat ∢? Yes 2∐1		od. Describe	r now injui	y occurred				
DIVISION For Attending	Director: A	fica	3 Suicide 6 Could no	t be 28e. Pi	lace of Injury	y - At home, f	arm, str	eet, factory							Rural Route Numi	ber,		
	of Dire	Certification;	4 Homicide building, etc. (Specify) City or Town, State)															
Hospital or A	To the Funerel Directo		29a. Certifier 1 Certifying (Check only 2 Medical Ex	kaminer: On th	ne basis of e	xamination a	ge, death	occurred	at the tim	ne, date an	d place, a	and due to the	e cause(s)	and manner	r as stated. due to the cause(s))		
To the h	the mpiet	Medical	one) and manner stated. 29b. Signature and title of certifier												9d. Date signed (Month, Day, Year)			
) P 3	₹ ¥ 8		Doc w									1911 7t 2007						
1			30. Name and address of person w	no completed (cause of dea	ith (Item 23a	(Type	Print)					TILL	/	~	-		
/			EBENEZE12	QUAIN	1001	nn	335	OU	1616	5N3.	· AV	F#3	67 K	ACT. 1	MD 212	25		
	Sta		31. Date filed (Month, Day, Year)	2007	2. Pegistrar													
4,1	Registr	ar	APR 1 0	2007	B. MUR.	15	A.	ale										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Madelaine Bayly Kirlin April 8 2007 4:37 рм /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2413cF Director 212-54-6577 56 Washington, March 11, 1951 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery <u>Kensington</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9520 Byeforde Road 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 📉 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 Ho Specify. White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Bayly ပ Salome Winters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael H. Kirlin/ Husband 9520 Byeforde Road, Kensington, MD 20895 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee #Paradon Home Inc. Kein Sille 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHERDSCLGROTIC UNKNUM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autonsy 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 Yes 2 No 24 hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 200 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. O'Bi2(FO, MD) & OVD GEOMGET. OLD GEMBET WN 31. Date filed (Month, Day, Year) Registrar's Signature State 1 0 2007 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760

Records,

Vital

Division or

elaino

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 **Physician** DM 2007 MARIE BARBARA KUNANIEC POG /Medical 4a. Facility Name (It not institution, give street and number)
Bel-AIV HEAlth and Rehab CEWler 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD BOI-AN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7/25/ 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 88 Director 216-01-2952 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b Count 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2905 Nelson Lane 21047 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10 Housewife O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of William Faber Mary 19a. Informant's Name/Relationship (Type, Prift)Daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Nelson Lane Fallston, MD. Barbara K. Bertling 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Depertment of Important: If eny injury or once. Gardens of Faith 4/18/2007 Rosedale, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland 21. Signal yre of Funeral Service Vicensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary **Physician** /Medical Examiner 3 weeks Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 2 No 3 Probably 4 Unknown 1 Tes cate has been signated to page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Dementia autopsy performed 1 ☐ Yes 2 ☐ No 20 No within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier To the 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063981 Mp. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Havre de Grace, 669 Revolution St Benjamin Lee, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

UNA NIEC,

			For State	State	of Marylan				ealth a Death	and M			20	0.7	100	0.0
			Registrar	lilica	le oi L	Jealii		Reg. No.			3. Time of Death					
	Physicia	1. Decedent's Name (First, Middle, Last) Physician									Month	Day		ear		
	/Medic	al	Hong-D				4h Oih	Town or	Leastion	of Dooth	April	5,	200 County of		9:21 P	•
F.	Examin	er	4a. Facility Name (If not institution,						Location o							
	inger en en en en en en en en en en en en en		18061 Singing					nery If Under:				Mont		ry ace (State or Fo	roian	
	Funeral	9		6. Sex 1 □ M 2 🖾 F	7. Age (In yrs.	34	Months		Hours	Min.	8. Date of Birth (Month, Day	, Year)		Count	try)	reigir
'n	Director		Usual Residence of Decedent		85						Sept.16	, 19	21 _	Lnao	nesia	
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside City Li	mits
DESILIMOTE, INISTY/ISING ALLID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	5	M1 - 1 M		M	ontgome	T	74110	0.0						1 □ Yes 2 🛭	No	
	Director	Maryland Montg 10e. Street and Number	omery	PIC	JIILBOIN		ip Code	ge			10a. Citiz	en of Wha	at Coun	trv?	-	
	۵			_										.,,		
	Funeral	18061 Singing Pa		le ecedent Ever in U	e 12 1		20886		ain? (Sne	oify Vec or No.		ndone		an Indian		
	er de Item ner n	ů	11. Marital Status	Armed	Forces?	.5.	If Yes, sp	ecify Cuba	in, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White, etc.			
20	s aft	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes,	s 2 X No Give Dates:		1 ☐ Yes	2 X No	Specify:				Specify:	A a f	an	
200	hour tural		15. Decedent	16a. Dece	dent's Us	ual Occuna	ation			Asian 16b. Kind of Business/Industry						
Ċ	"na" edici	Completed	(Specify only highest	(Give	kind of w	ork done d	during mos	t of worki	ng				,			
7	withii	E D	Elementary/Secondary (0-12)	rker	,				Farming							
7	Hygi Hygi Ither Int, tl	ပိ	17. Father's Name (First, Middle, L	.ast)					18. Mothe	er's Name	(First, Middle,	Maiden			<u> </u>	
ana	od o ed o	Be									Ada N	io	Kho			
Š	hould d Me mark natio	To	Kiem A	in Loe		19h Mailir	na Addres	s (Street :	and Numbe	er or Rum				ate Zin	Code) 2088	
	12sl han 7 is r traur					1										_
e,	l and Healt Sm 2		Helen Zeng/Daugh 20a. Method of Disposition	ter	20h	I 8061 Place of Dispo			Pine		Date MOI		cation - Ci		age, MD	•
0	ges t of H		1 ☐ Burial 2 ☑Cremation	3 □Removal fro	m State	cemetery, crei	matory or	other plac						•		
altimor	Fant: Pa	1	4 □ Donation 5 □ Other (Sp	ecify)	Met	ropoli									Virginia	a
<u>a</u>	epar epar npor ny in		21. Signature of Funeral Dervice Licensee () () () 22. Name and Address of Facility DeVol Funeral Home												_	
	20 E # 8		10 East Deer Park Dr., Gaithersburg, MD. 20877												<u>/</u>	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													n
	Physician		Immediate Cause (Final disease or condition Pneumonia												Oriset and Dear	uri
	/Medical		resulting in death) Due to (or as a consequence of):													
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Care hral Vascular Disease													
		ner														
	cuted d ansir	Examiner	Cause (Disease or injury that initiated events Cerebral Vascular Disease													
'n	exec an an rial-tr	E	resulting in death) Last	Due	to (or as a consec	quence of):										
2/60	death certificate be executed e attending physician and d for use as the burial-transit	dical		d												
Q	ificat g phy as th	edi		-2%												
X PO PO	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								2	23d. Date	of delive	ery		
Ď	leath atte	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No		☐Ectopic pregnancy ☐ Other (specify)					Month Day Ye			Day Year	r		
j.	y the	lysi	9☐Unknown													
J	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P								23e. Did to	Did tobacco use contribute to the cause of death?				h?
ecords	uires I sigr Id be	d by									10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown				
Ö	v req beer shou	Completed	24a. Was an								an	24b. Were autopsy findings available			ilable	
Ψ	ne law has b	d m									autor		pri	or to cor ath?	mpletion of caus	e of
=	cate ha	ပိ									1□ Yes	2 X No	1 [Yes	2□ No	
VITAI	Physician: The law rthis certificate has k ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Oth Oth	or.		ath (Check only one)					
0	shys this o	2	1 Yes 2X No			ER/Outpatie		JOA	4 LI INC		ome 5 Na Residence 6 □Other (Specify)					
	fter	ü	27. Manner of Death 1 Natural 5 Pending	(M	ate of Injury fonth, Day Year)	28b. Time of Injury		28c. Injur Wor	ƙ?		28d. Describe how injury occurred					
UIVISION	Attending r death. ector: Afte by the fune	Certification:	2 Accident investig		M		Yes 2□									
⋛	ter d irect	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)					ory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)					,
2	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	S														
	tosp t hor une ely fi	cal	(Check only 2 Medical !	Examiner: On the												
	the I	ledical	one) and manner stated.													
	Net To Con To Co	Σ	29b. Signature and title of certifier	~		*				100-		29d. Dat	~1			
	2		Kynikis.	m sh	lleon.	200 cm		770	058	032	2	Up.	ru	611	2007	
(\prec		30. Name and address of person													
_			Cynthia M. Will:	iams, M.	D., 6001	Munca	ster	Mill	Road	d, Ro	ockville	e, Ma	aryla	nd	20851	
	Sta	ate	31. Date filed (Month, Day, Year)	3 2007	2. Rafistrar's Sign	ature	1	s.C								

State of Maryland / Department of Health and Mental Hygiene State Registral Certificate of Death 2. Date of Death Month April 1. Decedent's Name (First, Middle, Last) 2007 **Physician** 2:00 PM 6 B. Lipp Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 51 Moonraker Rd. Ocean Pines If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F April 10,1930 PA Director 168-24-6654 76 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. fnside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumatic event, the Marcical Examinet rivat be notified at once. 1 ☐ Yes 2 No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 51 Moonraker Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 XNo Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Personnel Director Engineering 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Chester Arthur Lipp Helen Troutman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 King Rd., West Chester, PA 19580 R. Cheston Woolard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co. 4-9-2007 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service 108 William St., Berlin, Md. 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Myclodysplastic Syndrome **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner It perfencion and ekronic rendirentiona Hospital or Attending Physicien: The law requires that the death certificate be executed Due (or as a consequence of): Division of Vital Records, P.O. Box 68760, iobetes Millitus by Physician/Medical 15 400W IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural To the nospectation within 24 hours after deeth.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide to Cartifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00014314 April 9.2007 Farm. +12.10 llino. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANPITP KLUG. 145 E Conoll strut, Solis suy, MD. 21801 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State APR 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2007 6.00 A Kathryn Louisa Leadbeater 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Renaissance Gardens-Riderwood Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🗷 F 453-48-3230 92 December 5, 1914 **Illinois** Usual Residence of Decedent 10c. City, Town or Location 10a State 10d Inside City Limits 1 ☐Yes 2 No Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 3142 Gracefield Road, Apt. 306 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Howard Grayce Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Fallswood Drive, Rockville, Maryland 20854 Doug Makieg - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/10/2007 4 Donation 5 Other (Specify) Brentwood, Maryland Ft. Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Musel 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final onor disease or condition resulting in death) Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dron arc Due to (or as a conseque IF FEMALE: f yes, outcome pf pregnancy □Live birth 2□ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 | Pending Injury 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner the death certificate be executed and -trar physician ar s the burial-t Division or Vital Records, P.O. Box 68760, as use for detached the þ been signed to should be deta page 2 s certificate has Physician: funeral director, this After or Attending ours after death.

Ieral Director: A
filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

ns 23a (must b

"natural", or Items

th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Physician

Director

Funeral

Completed by

Be ည

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical 9 Completed Be Certification: To 29a. Certifie Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

Examiner

State Registrar

31. Date filed (Month, Day, Year) 0 9 200



and manner stated.

Mhumana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

9521

SILVERSPRING

29d. Date signed (Month, Day, Year)

2007

within 24 hours a

To the Funeral I

completely filled To the Hospital